BAYLOR GENETICS

BAYLOR GENETICS
2450 HOLCOMBE BLVD.
GRAND BLVD. RECEIVING DOCK
HOUSTON, TX 77021-2024

PHONE
1.800.411.4363
FAX
1.800.434.9850

CONNECT

POSTNATAL CMA / CYTOGENETICS REQUISITION

PATIENT INFORMATION (COMPLETE ONE FORM FOR EACH PERSON TESTED)

Patient Last Name | Patient First Name | MI | Date of Birth (MM / DD / YYYY)

Address | City | State | Zip | Phone

Accession # | Hospital / Medical Record #

Patient discharged from the hospital/facility: ◯ Yes ◯ No

Biological Sex: ◯ Female ◯ Male ◯ Unknown

Gender identity (if different from above):

REPORTING RECIPIENTS

Ordering Physician | Institution Name

Email (Required for International Clients) | Phone | Fax

ADDITIONAL RECIPIENTS

Name | Email | Fax

Name | Email | Fax

PAYMENT (FILL OUT ONE OF THE OPTIONS BELOW)

◯ **SELF PAYMENT**

☐ Pay With Sample ☐ Bill To Patient

◯ **INSTITUTIONAL BILLING**

Institution Name | Institution Code | Institution Contact Name | Institution Phone | Institution Contact Email

◯ **INSURANCE**

☐ Do Not Perform Test Until Patient is Aware of Out-Of-Pocket Costs (excludes prenatal testing)

REQUIRED ITEMS 1. Copy of the Front/Back of Insurance Card(s) 2. ICD10 Diagnosis Code(s) 3. Name of Ordering Physician 4. Insured Signature of Authorization

Name of Insured | Insured Date of Birth (MM / DD / YYYY)

Patient's Relationship to Insured | Phone of Insured

Address of Insured

City | State | Zip

Primary Insurance Co. Name | Primary Insurance Co. Phone

Primary Member Policy # | Primary Member Group #

Name of Insured | Insured Date of Birth (MM / DD / YYYY)

Patient's Relationship to Insured | Phone of Insured

Address of Insured

City | State | Zip

Secondary Insurance Co. Name | Secondary Insurance Co. Phone

Secondary Member Policy # | Secondary Member Group #

By signing below, I hereby authorize Baylor Genetics to provide my insurance carrier any information necessary, including test results, for processing my insurance claim. I understand that I am responsible for any co-pay, co-insurance, and unmet deductible that the insurance policy dictates, as well as any amounts not paid by my insurance carrier for reasons including, but not limited to, non-covered and non-authorized services. I understand that I am responsible for sending Baylor Genetics any and all payments that I receive directly from my insurance company in payment for this test. Please note that Medicare does not cover routine screening tests.

Patient's Printed Name | Patient's Signature | Date (MM / DD / YYYY)

STATEMENT OF MEDICAL NECESSITY (REQUIRED)

This test is medically necessary for the risk assessment, diagnosis, or detection of a disease, illness, impairment, symptom, syndrome, or disorder. The results will determine my patient's medical management and treatment decisions. The person listed as the Ordering Physician is authorized by law to order the test(s) requested herein. I confirm that I have provided genetic testing information to the patient and they have consented to genetic testing.

Physician's Printed Name | Physician's Signature | Date (MM / DD / YYYY)

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Patient Last Name | Patient First Name | MI | Date of Birth (MM / DD / YYYY) | Biological Sex

ETHNICITY

- ◯ African American
- ◯ Ashkenazi Jewish
- ◯ East Asian (China, Japan, Korea)
- ◯ Finnish
- ◯ French Canadian
- ◯ Hispanic American
- ◯ Mennonite
- ◯ Middle Eastern (Saudi Arabia, Qatar, Iraq, Turkey)
- ◯ Native American
- ◯ Northern European Caucasian (Scandinavian, UK, Germany)
- ◯ Pacific Islander (Philippines, Micronesia, Malaysia, Indonesia)
- ◯ South Asian (India, Pakistan)
- ◯ Southeast Asian (Vietnam, Cambodia, Thailand)
- ◯ Southern European Caucasian (Spain, Italy, Greece)
- ◯ Other (Specify): _____

INDICATION FOR TESTING (REQUIRED)

CMA OPTIONS

- ☐ Autism Spectrum
- ☐ Developmental Delay
- ☐ Dysmorphic Features
- ☐ Other (Specify): _____
- ☐ Failure to Thrive
- ☐ Multiple Congenital Anomalies
- ☐ Seizure Disorder

CHROMOSOME/FISH OPTIONS

- ☐ Autosomal Trisomies
- ☐ Ambiguous Genitalia
- ☐ Fetal Demise
- ☐ Other (Specify): _____
- ☐ Infertility
- ☐ Klinefelter/Turner
- ☐ Multiple Miscarriages

ICD10 Diagnosis Code(s): _____

SAMPLE INFORMATION

Date of Collection (MM / DD / YYYY)

SAMPLE TYPE

◯ Blood in EDTA Tube (Purple-Top) ◯ Blood in Sodium Heparin (Green-Top) ◯ Buccal Swab[1] ◯ Cord Blood

[1]Test codes 8665 and 6573 ONLY

CHROMOSOMAL MICROARRAY ANALYSIS (CMA) TESTS

Products of Conception (POC) and fetal tissue tests should be requested using the "Cytogenetics - Products of Conception Requisition", which can be found at baylorgenetics.com.

TEST CODE	TEST NAME	SAMPLE TYPE*	SPECIFY GENE OF INTEREST	SPECIFY REGION OF INTEREST
☐ 8665	Chromosomal Microarray Analysis (CMA) - HR + SNP Screen (Comprehensive)	BE + BH or BUC **only**		
☐ 8655	Chromosomal Microarray Analysis (CMA) - HR (Basic)	BE + BH		
☐ 8650	Chromosomal Microarray Analysis (CMA) - CytoScan HD SNP Array	BE + BH		

PARENTAL STUDIES RECOMMENDED IN CHILD'S CMA REPORT (ATTACH COPY)

☐ Mother _____ (First, MI, Last) _____ / _____ / _____ (Date of Birth (MM/DD/YYYY)) ◯ ASYMPTOMATIC ◯ SYMPTOMATIC (attach summary of findings)

☐ Father _____ (First, MI, Last) _____ / _____ / _____ (Date of Birth (MM/DD/YYYY)) ◯ ASYMPTOMATIC ◯ SYMPTOMATIC (attach summary of findings)

SAMPLE SPECIFICATIONS TABLE

ABBREVIATION	SAMPLE NAME	RECOMMENDED AMOUNT (2 YRS - ADULT)	RECOMMENDED AMOUNT (NEWBORN - 2 YRS)	SHIPPING INSTRUCTIONS	SPECIAL NOTES
BE	Blood in EDTA tube (purple-top)	3 - 5 cc	2 - 3 cc	Ship at room temperature in an insulated container by overnight courier. Do not heat or freeze.	
BH	Blood in Sodium Heparin tube (green top)	3 - 5 cc	1 - 2 cc	Ship at room temperature in an insulated container by overnight courier. Do not heat or freeze.	
BUC	Buccal Swab	See "Special Notes"	See "Special Notes"	Ship at room temperature in an insulated container by overnight courier. Do not heat or freeze.	Collect with ORAcollect•Dx (OCD-100) self-collection kit (provided by Baylor Genetics with instructions). We highly recommend the sample be collected by a healthcare professional. Buccal swab is an accepted sample type for Chromosomal Microarray Analysis - HR + SNP Screen (Comprehensive) (test code 8665) and FMR1 CGG Repeat Expansion Analysis (test code 6573) ONLY.
CB	Cord Blood	N/A	1 - 2 cc	Ship at room temperature in an insulated container by overnight courier. Do not heat or freeze.	Ensure properly labeled. Also send 3 cc of maternal blood in properly labeled EDTA tube for MCC studies at no charge as needed.

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Patient Last Name | Patient First Name | MI | Date of Birth (MM / DD / YYYY) | Biological Sex

CYTOGENETIC TESTS

Products of Conception (POC) and fetal tissue tests should be requested using the Cytogenetics - Products of Conception Requisition, which can be found at baylorgenetics.com

TEST CODE	TEST NAME	SAMPLE TYPE*
☐ 8600	Chromosome Analysis	BH
☐ 8480	FISH for SRY - Related Phenotypes (Metaphase & Interphase Cells) **	BH

** Testing on metaphase cells requires cell culturing.

NOTE: The following tests (8425 and 8426) REQUIRE selecting an accompanying test (8665, 8655, or 8600)

TEST CODE	TEST NAME	SAMPLE TYPE*
☐ 8425	Rapid FISH - AneuVysion (+13/+18/+21/X/Y) (Interphase cells ONLY)	BH
☐ 8426	Rapid FISH - Sex Chromosomes (X/SRY) (Interphase cells ONLY)	BH

+

TEST CODE	TEST NAME	SAMPLE TYPE*
☐ 8665	Chromosomal Microarray Analysis (CMA) - HR + SNP Screen (Comprehensive)	BE + BH or BUC **only**
☐ 8655	Chromosomal Microarray Analysis (CMA) - HR (Basic)	BE and BH
☐ 8600	Chromosome Analysis	BH

CMA + FMR1 TESTING - BUCCAL SWAB

NOTE: Only one buccal swab sample is needed if test codes 8665 and 6573 are ordered together.

TEST CODE	TEST NAME	SAMPLE TYPE*
☐ 8665	Chromosomal Microarray Analysis (CMA) - HR + SNP Screen (Comprehensive)	BUC
☐ 6573	FMR1 CGG Repeat Expansion Analysis	BUC

FISH STUDIES

Products of Conception (POC) and fetal tissue tests should be requested using the "Cytogenetics - Products of Conception Requisition", which can be found at baylorgenetics.com/requisitions/

TEST CODE	TEST NAME	SAMPLE TYPE*	TEST CODE	TEST NAME	SAMPLE TYPE*
☐ 8456	1p36 Deletion Syndrome	BH	☐ 8471	Miller-Dieker Syndrome	BH
☐ 8457	Adrenal Hypoplasia Congenita	BH	☐ 8435	Multiple Exostoses (EXT1 and EXT2) Panel	BH
☐ 8459	Angelman Syndrome	BH	☐ 8472	Multiple Exostoses Type I (EXT1)	BH
☐ 8460	Beckwith-Wiedeman Syndrome	BH	☐ 8473	Mulitple Exostoses Type II (EXT2 and ALX4)	BH
☐ 8462	Charcot-Marie-Tooth Neuropathy Type 1A	BH	☐ 8474	Neurofibromatosis Type I	BH
☐ 8464	Cri-Du-Chat Syndrome	BH	☐ 8476	Prader-Willi Syndrome	BH
☐ 8440	DiGeorge/Velocardiofacial Syndrome (22q and 10p) Panel	BH	☐ 8477	Rubinstein-Taybi Syndrome	BH
☐ 8486	DiGeorge/Velocardiofacial Syndrome Type I (22q)	BH	☐ 8478	Smith-Magenis Syndrome	BH
☐ 8465	DiGeorge/Velocardiofacial Syndrome Type II (10p)	BH	☐ 8479	Sotos Syndrome	BH
☐ 8466	Glycerol Kinase Deficiency	BH	☐ 8480	SRY-Related Phenotypes	BH
☐ 8467	Hereditary Neuropathy w/ Liability to Pressure Palsies	BH	☐ 8482	Trichorhinophalangeal Syndrome Type I	BH
☐ 8458	JAG1-Related Alagille Syndrome	BH	☐ 8450	WAGR (WT1 and PAX6) Panel	BH
☐ 8469	Kallmann Syndrome Type I	BH	☐ 8483	Williams Syndrome	BH
☐ 8430	Langer-Giedion Syndrome (EXT1 and TRPS1)	BH	☐ 8455	Wilms Tumor (WT1)	BH
☐ 8468	LIS1-Associated Lissencephaly	BH	☐ 8484	Wolf-Hirschhorn Syndrome	BH
☐ 8470	Microphthalmia w/ Linear Skin Lesions (MLS/MIDAS)	BH	☐ 8485	X-Linked Ichthyosis	BH

* Refer to Sample Specifications Table (page 2)