

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) _____	Name of Insured _____	Insured Date of Birth (MM / DD / YYYY) _____
Patient's Relationship to Insured _____	Phone of Insured _____	Patient's Relationship to Insured _____	Phone of Insured _____
Address of Insured _____		Address of Insured _____	
City _____	State _____ Zip _____	City _____	State _____ Zip _____
Primary Insurance Co. Name _____	Primary Insurance Co. Phone _____	Secondary Insurance Co. Name _____	Secondary Insurance Co. Phone _____
Primary Member Policy # _____	Primary Member Group # _____	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) _____

POSTNATAL CMA / CYTOGENETICS REQUISITION

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

ETHNICITY

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

INDICATION FOR TESTING (REQUIRED)

CMA OPTIONS

- | | |
|---|--|
| <input type="checkbox"/> Autism Spectrum | <input type="checkbox"/> Failure to Thrive |
| <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Multiple Congenital Anomalies |
| <input type="checkbox"/> Dysmorphic Features | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Other (Specify): _____ | |

CHROMOSOME/FISH OPTIONS

- | | |
|---|--|
| <input type="checkbox"/> Autosomal Trisomies | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Ambiguous Genitalia | <input type="checkbox"/> Klinefelter/Turner |
| <input type="checkbox"/> Fetal Demise | <input type="checkbox"/> Multiple Miscarriages |
| <input type="checkbox"/> Other (Specify): _____ | |

ICD10 Diagnosis Code(s): _____

SAMPLE INFORMATION

_____/_____/_____
 Date of Collection (MM / DD / YYYY)

SAMPLE TYPE

- | | | |
|---|-----------------------------------|------------------------------|
| <input type="radio"/> Blood in EDTA Tube (Purple-Top) | <input type="radio"/> Buccal Swab | <input type="radio"/> Saliva |
| <input type="radio"/> Blood in Sodium Heparin (Green-Top) | <input type="radio"/> Cord Blood | |

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
<input type="checkbox"/> 8665	Chromosomal Microarray Analysis (CMA) - HR + SNP Screen (Comprehensive)	BE + BH or BUC only		
<input type="checkbox"/> 8655	Chromosomal Microarray Analysis (CMA) - HR (Basic)	BE + BH		

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

- | | | | | |
|---------------------------------|--------------------------------------|---|------------------------------------|--|
| <input type="checkbox"/> Mother | _____/_____/_____
First, MI, Last | _____/_____/_____
Date of Birth (MM/DD/YYYY) | <input type="radio"/> ASYMPTOMATIC | <input type="radio"/> SYMPTOMATIC (attach summary of findings) |
| <input type="checkbox"/> Father | _____/_____/_____
First, MI, Last | _____/_____/_____
Date of Birth (MM/DD/YYYY) | <input type="radio"/> ASYMPTOMATIC | <input type="radio"/> SYMPTOMATIC (attach summary of findings) |

SAMPLE SPECIFICATIONS TABLE

ABBREVIATION	SAMPLE NAME	RECOMMENDED AMOUNT		SHIPPING INSTRUCTIONS	SPECIAL NOTES
		(2 YRS - ADULT)	(NEWBORN - 2 YRS)		
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.
SA	Saliva	See "Special Notes"	See "Special Notes"	Ship at room temperature in an insulated container by overnight courier. Do not heat or freeze.	Collected with Oragene DNA Self-Collection Kit (provided by Baylor Genetics with instructions).



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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*
<input type="checkbox"/> 8600	Chromosome Analysis	BH
<input type="checkbox"/> 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*
<input type="checkbox"/> 8425	Rapid FISH - AneuVysion (+13/+18/+21/X/Y) (Interphase cells ONLY)	BH
<input type="checkbox"/> 8426	Rapid FISH - Sex Chromosomes (X/SRY) (Interphase cells ONLY)	BH



TEST CODE	TEST NAME	SAMPLE TYPE*
<input type="checkbox"/> 8665	Chromosomal Microarray Analysis (CMA) - HR + SNP Screen (Comprehensive)	BE + BH or BUC only
<input type="checkbox"/> 8655	Chromosomal Microarray Analysis (CMA) - HR (Basic)	BE and BH
<input type="checkbox"/> 8600	Chromosome Analysis	BH

CMA + FMR1 TESTING

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

TEST CODE	TEST NAME	SAMPLE TYPE*
<input type="checkbox"/> 8665	Chromosomal Microarray Analysis (CMA) - HR + SNP Screen (Comprehensive)	BE+BH or BUC only
<input type="checkbox"/> 6573	FMR1 CGG Repeat Expansion Analysis	BE, BUC, SA

If negative, reflex to:

TEST CODE	TEST NAME
<input type="checkbox"/> 1500	Proband Whole Exome Sequencing
<input type="checkbox"/> 1600	Trio Whole Exome Sequencing
<input type="checkbox"/> 1602	Additional Affected Sibling for Trio*

* The Sibling Trio should be ordered along with, or after a completed Trio (#1600) for the same biological family.

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*
<input type="checkbox"/> 8456	1p36 Deletion Syndrome	BH	<input type="checkbox"/> 8435	Multiple Exostoses (EXT1 and EXT2) Panel	BH
<input type="checkbox"/> 8457	Adrenal Hypoplasia Congenita	BH	<input type="checkbox"/> 8472	Multiple Exostoses Type I (EXT1)	BH
<input type="checkbox"/> 8459	Angelman Syndrome	BH	<input type="checkbox"/> 8473	Multiple Exostoses Type II (EXT2 and ALX4)	BH
<input type="checkbox"/> 8460	Beckwith-Wiedeman Syndrome	BH	<input type="checkbox"/> 8474	Neurofibromatosis Type I	BH
<input type="checkbox"/> 8462	Charcot-Marie-Tooth Neuropathy Type 1A	BH	<input type="checkbox"/> 8476	Prader-Willi Syndrome	BH
<input type="checkbox"/> 8464	Cri-Du-Chat Syndrome	BH	<input type="checkbox"/> 8477	Rubinstein-Taybi Syndrome	BH
<input type="checkbox"/> 8440	DiGeorge/Velocardiofacial Syndrome (22q and 10p) Panel	BH	<input type="checkbox"/> 8478	Smith-Magenis Syndrome	BH
<input type="checkbox"/> 8486	DiGeorge/Velocardiofacial Syndrome Type I (22q)	BH	<input type="checkbox"/> 8479	Sotos Syndrome	BH
<input type="checkbox"/> 8465	DiGeorge/Velocardiofacial Syndrome Type II (10p)	BH	<input type="checkbox"/> 8480	SRY-Related Phenotypes	BH
<input type="checkbox"/> 8466	Glycerol Kinase Deficiency	BH	<input type="checkbox"/> 8482	Trichorhinophalangeal Syndrome Type I	BH
<input type="checkbox"/> 8467	Hereditary Neuropathy w/ Liability to Pressure Palsies	BH	<input type="checkbox"/> 8450	WAGR (WT1 and PAX6) Panel	BH
<input type="checkbox"/> 8458	JAG1-Related Alagille Syndrome	BH	<input type="checkbox"/> 8483	Williams Syndrome	BH
<input type="checkbox"/> 8469	Kallmann Syndrome Type I	BH	<input type="checkbox"/> 8455	Wilms Tumor (WT1)	BH
<input type="checkbox"/> 8430	Langer-Giedion Syndrome (EXT1 and TRPS1)	BH	<input type="checkbox"/> 8484	Wolf-Hirschhorn Syndrome	BH
<input type="checkbox"/> 8468	LIS1-Associated Lissencephaly	BH	<input type="checkbox"/> 8485	X-Linked Ichthyosis	BH
<input type="checkbox"/> 8470	Microphthalmia w/ Linear Skin Lesions (MLS/MIDAS)	BH	<input type="checkbox"/> 8490	Chromosome X and Y Centromere Analysis	BH
<input type="checkbox"/> 8471	Miller-Dieker Syndrome	BH			

* Refer to Sample Specifications Table (page 2)