GENESYS Diagnostics INC.
8 EnterpriseLane,OakdaleCT-06370,
Tel:(860) 574-9172, Fax: (860) 574-9264,
Email: info@gdilabs.com

CT-ST License # CL-0687

Pediatric Requisition Form

1: PATIENT INFORMATION

Billing # Client #	PATIENT NAME (LAST) (FIRST) (M.I.)		Electronic Medical Record #	Hospital /Accession#
	PATIENT ADDRESS (STREET)	CITY	STATE	ZIP
	PATIENT PHONE	Drawn By		
	Date & Time Collected	☐ Male☐ Female		BIRTH DATE(Month/Day/Year)
Ordering Physician Name & Signature	MEDICARE/MED. NUMBER	STATE		
	MEDICAL ASSISTANCE NUMBER	STATE		
Genetic Counselor	POLICY HOLDER NAME	POLICY HOLDER DATE OF BIRTH	MEMBER/POLICY #	GROUP #
	RELATIONSHIP OF PATIENT TO INSURED ☐ SELF ☐ SPOUSE ☐ DEPENDENT	INSURANCE CO. NAME		
Phone: **Fax:**	**ICD DIAGNOSIS CODE(S) FOR TESTS ORDERED (MUST BE PROVIDED)**			
	Dx1	**Dx2**	**Dx3**	**Dx4**
	Medical Necessity Statement: Tests ordered on Medicare patients must follow CMS rules regarding medical necessity and FDA approval guidelines and must include diagnosis, symptoms and reason for testing as indicated in the medical record. If testing does not come under Medicare guidelines for payment a 'signed' Advanced Beneficiary Notice must be included.			

2: SPECIMEN TYPE

☐ Peripheral Blood ☐ Buccal /Saliva Swab

3:INDICATION

☐ Family History of Disease or Disorders (Z84.89)
☐ Consanguinity (Z84.3)
☐ Developmental Delay (F88)
☐ Multiple anomalies (Q89.7)
☐ Autism Spectrum Disorder (F84.0)
☐ Dysmorphic features (Q18.9, Q79.9)
☐ Other:

4: CHROMOSOME ANALYSIS (Blood Only) ☐ Yes ☐ No Please Check One

5: FISH STUDIES (Blood Only) (circle one) RUN OR HOLD

FISH FOR ANEUPLOIDY
☐ (AneuVysion) X/Y/18/13/21
☐ X/Y/18 ONLY
☐ 13/21 ONLY
☐ Trisomy 21 - Down Syndrome
☐ Trisomy 18 - Edwards Syndrome
☐ Trisomy 13 - Patau Syndrome

FISH FOR SEX CHROMOSOME ABNORMALITIES:
☐ Sex Determination (X/SRY)
☐ Turner Syndrome (CEPX/CEPY)
☐ Klinefelter Syndrome (CEPX/CEPY)

FISH FOR MICRODELETION SYNDROMES

☐ Angelman syndrome	15q11-13	☐ Soto syndrome	5q35
☐ Cri du Chat-syndrome	5p15.2	☐ SRY	Yp11.3
☐ DiGeorge/VCFS/CATCH22	22q11.2	☐ Steroid Sulfatase (STS)	Xp22.3
☐ Kallmann syndrome	Xp22.3	☐ Wolf-Hirschhorn syndrome	4p16.3
☐ Miller-Dieker syndrome	17p13.3	☐ Williams Beuren syndrome	7q11.23
☐ Prader-Willi syndrome	15q11-13	☐ XIST	Xq13.2
☐ Smith-Magenis syndrome	17p 11.2	☐ Other _____	

6: MICROARRAY ANALYSIS

☐ MicroArray Analysis for Autism and other neurobehavioral disorders

7: OTHER TESTS PROVIDED

☐ Fragile X Syndrome ☐ Autism Sequencing Panel

8: PATIENT BILLING INFORMATION:

PLEASE INCLUDE A COPY OF THE INSURANCE CARD(S) FOR BILLING PUPPOSES.

☐ CLIENT BILL	☐ INSURANCE	☐ MEDICARE/MEDICAID	☐ SELF PAY

9: PATIENT/PARENT/GUARDIAN AUTHORIZATION

I understand that I am responsible for providing accurate information about my insurance to Genesys Diagnostics Inc. I understand that Genesys Diagnostics Inc. will be providing testing service and billing my insurance. However, I understand that charges that are not covered by my insurance, including any applicable co-payments and deductibles are my responsibility and I agree to pay such charges promptly.

Signature of Patient/Responsible Party (REQUIRED)_____Date (Required)_____

10: HEALTHCARE PROVIDER AUTHORIZATION

I certify that (i) this test is medically necessary, (ii) the patient (or authorized representative on the patient's behalf) has given informed consent (which includes written informed consent or written authorization when required by law) to have this testing performed, and (iii) the informed consent obtained from the patient meets the requirements of applicable law and Genesys's Patient Informed Consent. I agree to provide Genesys, or its designee, any and all additional information reasonably required for this testing to be performed.

Signature of Healthcare Provider (Required)_____Date (Required) _____

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Pediatric Specimen Collection and Shipping Instructions

SPECIMEN COLLECTION INSTRUCTIONS

Test	Specimen Type	Volume	Container	Storage Conditions	Special Instructions
Chromosome Analysis & FISH,	Peripheral Blood	Adult/Child: 5-10 ml Newborn: 3-5 ml	Sodium Heparin Green-top Tube	Room Temperature or Refrigerate	Do Not Freeze
Fragile X & Microarray Other Molecular Tests	Peripheral Blood	Adult/Child: 5-10 ml Newborn: 3-5 ml	EDTA Tube Purple-top Tube	Room Temperature or Refrigerate	Do Not Freeze

SPECIMEN SHIPPING INSTRUCTIONS – FEDERAL EXPRESS SHIPPING INSTRUCTIONS

- Use sterile technique for specimen collection and close all containers tightly. **DO NOT FREEZE OR ADD FIXATIVE TO ANY SAMPLE.** Each specimen must be clearly labeled with at least two patient identifiers (patient's name and date of birth), along with the collection date. Secure each specimen container tightly to avoid leakage in transit.
- Complete the test requisition with the patient's demographics and insurance information. There is a secondary pouch in the biohazard bag for the test requisition. The clinical indication is required for appropriate cell culture parameters.
- Place the specimen in the absorbent material inside the enclosed biohazard bag. Then place the biohazard bag into the insulated specimen box labeled "Biohazardous Material" "Exempt Human Specimen". Please package the specimen carefully to protect it from breakage, leakage, and extreme temperatures. Place the specimen box inside the enclosed FedEx Clinical Pak (lab shipping bag) and seal.
- Attach the pre-labeled and prepaid FedEx air bill. You can call **FedEx at (800) 463-3339** to schedule a FedEx pickup. Alternately, a pick-up can be scheduled online at www.fedex.com . A two-hour notice may be required for same-day pick-up. Delivery address: **8 Enterprise Lane, Oakdale CT, 06370**, via FedEx overnight.
- Contact Laboratory for additional shipping materials, further instructions or any questions: **860-574-9172.**