DATE

PATIENT NAME: LAST FIRST

Address/Phone: DOB

ORDERED BY:

COLLECTED BY:

DATE TIME AM PM

Medical Record #

DIAGNOSIS/ICD Code(s) **required**:

UPSTATE
UNIVERSITY HOSPITAL
Molecular Diagnostics
DNA Based Genetic Testing
750 East Adams Street
Syracuse, NY 13210
(315) 464-6806
Fax: (315) 464-6827

As the referring physician, I certify that the tests ordered below are medically necessary for the diagnosis or treatment of this patient.

Requesting Physician (print):_____

Physician Signature: _____

Address: _____ Phone: _____

For Lab Use Only:

Case No: _____

Date Received: _____/_____/_____

SPECIMEN REQUIREMENT: Adults and children: 10 mL EDTA; infants: 1-2 mL EDTA (pediatric tube). Store at room temperature; receipt Monday - Friday, within 24 hours of collection. **Informed consent required**.

LABORATORY TESTS ORDERED

		Cystic Fibrosis Direct Mutation Analysis (41 mutations) Delta F508 only Linkage analysis 3199del6 (patients with I148T only) Other CF mutations:
		Fragile X detection
		Hereditary Hemochromatosis (C282Y & H63D)
		Thrombophilia Factor V (Leiden and D2194G) (Leiden positive refer to D2194G)
		Prothrombin 20210G>A
		MTHFR (C677T)
		Other:

CLINICAL INFORMATION/TESTS INDICATIONS (CHECK ALL THAT APPLY)

Date drawn: ___/___/___ Date sent: ___/___/___ Drawn by:_____

Pregnancy: □ No □ Yes Gestation _____weeks

Specimen: □ Blood □ DNA □ Amniotic fluid culture □ Other

Ethnicity: □ Caucasian □ Jewish-Ashkenazi □ Hispanic

□ African American □ Native American □ Asian

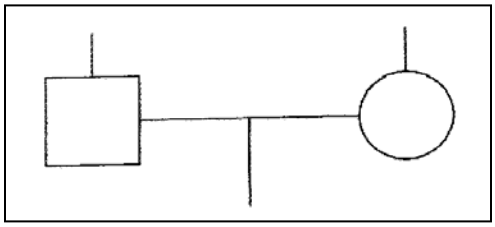
□ Other: _____

INDICATIONS FOR TEST (CHECK ALL THAT APPLY)

Diagnostic: □ Known affected
□ Suspected: Symptoms _____

Carrier: □ Family history (attach pedigree)
□ No family history (population screening)

Please complete pedigree: (or attach as separate sheet)



BILLING INFORMATION: ATTACH A COPY OF INSURANCE CARD AND AUTHORIZATION. INSURANCE BILLING REQUIRES PATIENT/INSURED SIGNATURE.

□ B/C B/S □ Indemnity □ Medical Group/IPA □ HMO □ PPO □ Network
□ Medicare (Copy of card required) □ Medicaid (Copy of card required) □ Self-pay

Policy #: _____ Group #: _____

Ins. Company Name: _____

Network Name: _____

Claims Address: _____

City, State, Zip: _____,_____,_____

Telephone: _____

Name of Insured: _____

Relation to Insured □ Self □ Spouse □ Child □ Other _____

Authorization/Referral #: _____

I hereby authorize SUNY Upstate Medical University to furnish my designated insurance carrier the information on this form if necessary for reimbursement. I also authorize benefits to be payable to SUNY Upstate Medical University. I understand that I am responsible for any amount not paid by insurance for reasons including, but not limited to, non-covered and non-authorized services. I permit a copy of this authorization to be used in place of the original.

Patient/Responsible Party Signature: _____ Date: _____