GENETICS LABORATORY
MOLECULAR REQUISITION FORM
DISEASE SPECIFIC DNA TESTING

Ship To: O'Donoghue Research Bldg
1122 NE 13 Street, Suite 1400
Oklahoma City, OK 73104
Phone: 405-271-3589
Fax: 405-271-7117
After hours phone: 405-496-9514
www.genetics.ouhsc.edu

PLEASE COMPLETE ALL FORMS AND SEND WITH PATIENT SAMPLE

Courier Service in OKC metro area call Rapid Transit 793-1122 for specimen pickup

REFERRING PHYSICIAN/FACILITY

Physician Name ____

NPI ____

Phone (____)____________________ Fax(___)____________________

Genetic Counselor____________________Phone (____)______________

Laboratory/Institution____

Phone (___)____________________ Fax (____)____________________

Address ____

City __________________________ State______________ Zip_________

Phone (____)____________________ Fax (____)____________________

PATIENT AND BILLING INFORMATION

Patient Name (last,first,m.)______________________________________

Parent Name (if pt is a minor)______________________________________

DOB___________ SSN________________________ MRN_____________

Sex: ☐ Male ☐ Female ☐ Ambiguous ☐ Unknown ☐ Inpatient ☐ Outpatient

Ethnicity of patient (check all that apply)
☐ African-American ☐ Asian ☐Caucasian/NW European ☐ E. Indian
☐ Hispanic ☐ Jewish-Ashkenazi ☐ Jewish-Sephardic ☐ Native American
☐ Native Hawaiian/Other Pacific Islander ☐ Other_________________

Patient's Address____

City______________________________ State_______ Zip Code_________

SPECIMEN/CLINICAL INFORMATION

Diagnosis/Clinical Findings/Family History____

You may also list ICD-9 codes

Date Specimen Collected____________________ Time__________

SPECIMEN TYPES & COLLECTION REQUIREMENTS

☐ **Peripheral Blood**
3-5 cc in a large EDTA tube (purple top),mix well. Specimen must be kept at room temperature or cooler, do not freeze.

☐ **Amniotic Fluid** **Do Not Transport Specimen in Syringes!**
Collect 5-10 cc of fluid and transfer to sterile centrifuge tubes. Keep specimen cool but do not freeze. **Gestational age by:**
ultrasound_________ or LMP__________
Gravida__ __ Para__ __ __ __

☐ **Isolated DNA**
Contact laboratory to obtain concentration and volumes that are required. DNA isolation must have taken place in a CLIA-certified laboratory or a lab meeting equivalent requirements as determined by CAP and/or CMS.

TEST INFORMATION

Please Select One of the Following Studies:
☐ Angelman syndrome (methylation)
☐ Beckwith Wiedemann/Russell Silver syndromes
☐ CGH Microarray
☐ Cystic Fibrosis (137 mutation panel)
☐ Fragile X (PCR/Southern blot)
☐ Huntington Disease (PCR/Southern blot)
☐ Hypotonia Panel (PWS, SMN1, DMPK assays performed)
☐ Myotonic Dystrophy *DMPK* gene (PCR)
☐ Prader Willi syndrome (methylation)
☐ Sickle Cell disease
☐ SNP Microarray
☐ Spinal Muscular Atrophy *SMN1/2* (exon 7 deletion)
☐ Y chromosome deletion

☐ Uniparental disomy (UPD) chromosome_______
(For this test collect blood from both biological parents and child)

ADDITIONAL REPORT

Physician/Facility__________________________________

Phone_(___)__________________ Fax_(___)________________

Address____

____

8/2018

GENETICS LABORATORY USE ONLY

Laboratory Number______________________________________

Date & Time of Pick-Up/Delivery______________________________

Location____

Initials__________ Check-in___________

Additional Specimen(s)sent for patient_______________

Previous Lab Number______________________________________

Genetics Laboratory
Billing Information Form

Patient Name LAST____ FIRST______________________________________ MI______

YOU MUST CHOOSE ONE OF THE THREE BILLING OPTIONS LISTED BELOW.
PLEASE FORWARD ALL BILLING QUESTIONS TO DANIELLE OTIS AT DOTIS@OUHSC.EDU OR CALL 405-271-3589 OPT 4
AT THIS TIME WE DO NOT ACCEPT OUT-OF-STATE MEDICAID

PAYMENT OPTION 1-INSTITUTION

INSTITUTION NAME ____

BILLING ADDRESS____

CITY, STATE, ZIP ____ CONTACT NAME______________________________________

PHONE NUMBER_____________________ FAX NUMBER_____________________ CONTACT EMAIL ADDRESS ___________________________________

PAYMENT OPTION 2-SELF PAY (PAYMENT MUST BE SENT WITH SAMPLE)

☐ **CREDIT CARD** (CIRCLE ONE) AMEX DISCOVER VISA MASTERCARD AMOUNT TO CHARGE____

VALID CARD # ____ EXP DATE____

CVV CODE ______________ CARDHOLDER PRINTED NAME____

BILLING ADDRESS ____ CITY, STATE, ZIP____

CARDHOLDER SIGNATURE ____

☐ **CHECK #** _____________________________ AMOUNT ENCLOSED____

PAYMENT OPTION 3-INSURANCE PROVIDE A LEGIBLE COPY OF THE FRONT & BACK OF INSURANCE CARD
PLEASE NOTE: OUR FACILITY WILL CONFIRM COVERAGE AND VERIFY WHETHER OR NOT THE TEST(S) ORDERED ARE COVERED BY YOUR PLAN.
OUR OFFICE CAN ALSO OBTAIN PRE-AUTHORIZATION FROM THE INSURANCE PLAN.

PRIMARY INSURANCE POLICYHOLDER NAME ____ POLICYHOLDER DOB______________________

PRIMARY POLICYHOLDER SS# ______________________________________ GENDER: M F EMPLOYER_____________________________________

RELATIONSHIP TO PATIENT______________________________ POLICY # ____

GROUP #____ INSURANCE CO. NAME ____

PHONE ____ CLAIMS ADDRESS ____

CITY, STATE, ZIP____ INSURANCE AUTH #____

SECONDARY INSURANCE POLICYHOLDER NAME ______________________________________ POLICYHOLDER DOB_____________________________

SECONDARY POLICYHOLDER SS# ___________________________________ GENDER: M F EMPLOYER_____________________________________

RELATIONSHIP TO PATIENT_______________________________ POLICY # ____

GROUP #____ INSURANCE CO. NAME ____

PHONE ____ CLAIMS ADDRESS ____

CITY, STATE, ZIP____ INSURANCE AUTH #____

I CONSENT TO HAVE THE TEST(S) LISTED ON THE PREVIOUS PAGE PERFORMED. I AUTHORIZE THE UNIVERSITY OF OKLAHOMA HSC GENETICS LABORATORY TO FURNISH ANY MEDICAL INFORMATION REQUESTED ON MYSELF, OR MY COVERED DEPENDENTS. IN CONSIDERATION OF SERVICES RENDERED, I TRANSFER AND ASSIGN ANY BENEFITS OF INSURANCE TO UNIVERSITY OF OKLAHOMA HSC GENETICS LABORATORY. I UNDERSTAND I AM RESPONSIBLE FOR ANY CO-PAY, DEDUCTIBLES, OR NON-AUTHORIZED SERVICES AND REMAINING BALANCES AFTER INSURANCE REIMBURSEMENT. I UNDERSTAND I AM FULLY RESPONSIBLE FOR PAYMENT OF MY ACCOUNT IF THE UNIVERSITY OF OKLAHOMA HSC GENETICS LABORATORY IS NOT A PARTICIPANT WITH MY HEALTH PLAN OR MY HEALTH PLAN DOES NOT FULLY REIMBURSE MY MEDICAL SERVICES DUE TO LACK OF AUTHORIZATION OR MEDICAL NECESSITY.

PRINTED NAME ____ SIGNATURE____ DATE _______________