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| Seattle Children's MRN: | Seattle Children's Account Number: | Processed By: | Date: |
| FAILURE TO COMPLETE MAY DELAY RESULTS | | | |
| Patient's Last Name | | First | Middle |
| Outside Patient Number | | Outside Specimen Number | Send Report To: |
| Ordering Provider | | Address: | |
| Provider Phone Number | DIAGNOSIS / ICD-9: | | Phone/Fax #: |
| IMPORTANT INFORMATION REGARDING BILLING AND MEDICAL NECESSITY: | | | |
| *ALL SAMPLES WILL BE BILLED TO THE REFERRING INSTITUTION UNLESS COMPLETE BILLING AND DIAGNOSIS INFORMATION IS PROVIDED ON THE BACK OF THIS FORM. CONTACT SEATTLE CHILDREN'S LABORATORY CLIENT SERVICES FOR ADDITIONAL ASSISTANCE. (206) 987-2617 | | | |
| PHYSICIAN NOTIFICATION: Only tests that you believe are appropriate for patient care should be ordered. Medicare/Medicaid will pay only for tests that are medically necessary for the diagnosis and treatment of the patient, rather than for screening purposes. | | | |
| ***REQUIRED INFORMATION***: | | | |
| Healthcare professional to call for information/abnormal results: NAME (please print): _____ PHONE#: _____ | | | |

SPECIMEN INFORMATION: Date collected: ____ / ____ / ____
 Time collected: _____

Whole Blood: Na Heparin Other (tissue / fibroblast): _____
 EDTA ACD _____

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| ARRAY SNP TESTING (Requires EDTA Purple Top AND NaHEP Green Top) |
| CH-SNP <input type="checkbox"/> SNP Array CH-PARSNP <input type="checkbox"/> Parental SNP follow-up |
| CYTOGENETIC TESTING |
| CH-KARY <input type="checkbox"/> Peripheral blood karyotype <input type="checkbox"/> Sex determination - STAT CH-KARY <input type="checkbox"/> Peripheral blood karyotype + R/O mosaicism for _____ CH-FISH <input type="checkbox"/> Fluorescence <i>in situ</i> hybridization (FISH) <input type="checkbox"/> Velocardiofacial (VCF)/DiGeorge Syndrome 22q11.2 deletion/duplication syndrome <input type="checkbox"/> Williams Syndrome <input type="checkbox"/> Other: _____ CH-FAMS <input type="checkbox"/> Family Study (limited work-up; provide pedigree) CH-KARY <input type="checkbox"/> Workup for Turner Syndrome CH-KARY <input type="checkbox"/> Workup for ambiguous genitalia FISH for SRY? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| SKIN FIBROBLAST TESTING |
| CH-SKIN <input type="checkbox"/> Solid Tissue - Fibroblast culture ONLY CH-SKIN <input type="checkbox"/> Solid Tissue - Fibroblast culture + Karyotype CH-SKIN <input type="checkbox"/> Other Tissue Karyotype: Source: _____ |

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| CLINICAL FINDINGS & FAMILY HISTORY |
| ***Please include either Diagnosis/ICD-9 Code and/or Clinical Findings for all Cytogenetic testing*** |
| _____ _____ _____ _____ _____ _____ <div style="text-align: center; margin-top: 20px;">(OPEN SPACE FOR PEDIGREE)</div> |

(206) 987-2102

sc 6/11