

PATIENT NAME: LAST _____ FIRST _____ Address/Phone: _____ DOB _____	ORDERED BY: _____ COLLECTED BY: _____ DATE _____ TIME _____ AM _____ PM	 University Hospital MEDICINE AT ITS BEST® Molecular Diagnostics DNA Based Genetic Testing 750 East Adams Street Syracuse, NY 13210 (315) 464-6806 Fax: (315) 464-6827
Medical Record # _____	DIAGNOSIS/ICD-9 Code required: _____	

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

LABORATORY TESTS ORDERED	CLINICAL INFORMATION/TESTS INDICATIONS (CHECK ALL THAT APPLY)
Alpha-1 antitrypsin deficiency (Z & S)	Date drawn: ____/____/____ Date sent: ____/____/____ Drawn by: _____
Cystic Fibrosis	Pregnancy: <input type="checkbox"/> No <input type="checkbox"/> Yes Gestation _____ weeks
Direct Mutation Analysis (25 mutations)	Specimen: <input type="checkbox"/> Blood <input type="checkbox"/> DNA <input type="checkbox"/> Amniotic fluid culture <input type="checkbox"/> Other
Delta F508 only	Ethnicity: <input type="checkbox"/> Caucasian <input type="checkbox"/> Jewish - Ashkenazi <input type="checkbox"/> Hispanic
Linkage analysis	<input type="checkbox"/> African American <input type="checkbox"/> Native American <input type="checkbox"/> Asian
3199del6 (patients with I148T only)	<input type="checkbox"/> Other: _____
Other CF mutations:	
Factor XI (F283L & E117X)	
Fragile X detection	
	INDICATIONS FOR TEST (CHECK ALL THAT APPLY)
Hereditary Hemochromatosis (C282Y & H63D)	Diagnostic: <input type="checkbox"/> Known affected <input type="checkbox"/> Suspected: Symptoms _____
Sickle cell anemia (S&C)	Carrier: <input type="checkbox"/> Family history (attach pedigree) <input type="checkbox"/> No family history (population screening)
Thrombophilia	Please complete pedigree: (or attach as separate sheet)
Factor V (Leiden and D2194G) (Leiden positive reflex to D2194G)	
Prothrombin 20210G>A	
MTHFR (C677T)	
Maternal Cell Contamination (MCC) Analysis	
Other:	



BILLING INFORMATION: ATTACH A COPY OF INSURANCE CARD AND AUTHORIZATION. INSURANCE BILLING REQUIRES PATIENT/INSURED SIGNATURE.	
<input type="checkbox"/> B/C B/S <input type="checkbox"/> Indemnity <input type="checkbox"/> Medical Group/IPA <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> Network <input type="checkbox"/> Medicare (Copy of card required) <input type="checkbox"/> Medicaid (Copy of card required) <input type="checkbox"/> Self-pay Policy #: _____ Group #: _____ Ins. Company Name: _____ Network Name: _____	Claims Address: _____ City, State, Zip: _____, _____, _____ Telephone: _____ Name of Insured: _____ Relation to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> 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: _____	