BAYLOR GENETICS
READY WITH ANSWERS

SHIPPING Baylor Genetics
2450 Holcombe Blvd., Grand Blvd. Receiving Dock
Houston, TX 77021-2024
Phone: 713.798.6555
Fax: 713.798.2787

POSTNATAL CMA / CYTOGENETICS REQUISITION

PATIENT INFORMATION (COMPLETE ONE FORM FOR EACH PERSON TESTED)

Patient Last Name | Patient First Name | MI | Date of Birth (MM/DD/YY)

Address | Accession # | Hospital/ Medical Record #

Biological Sex: ◯ M ◯ F ◯ Unknown

City | State | Zip | Phone

Gender identity (if different from above):

REPORTING RECIPIENTS

Ordering Physician | Institution Name

Email (Required for International Clients) | Phone | Fax

◆ **ADDITIONAL RECIPIENTS**

Name | Name

Email | Fax | Email | Fax

PAYMENT (FILL OUT ONE OF THE OPTIONS BELOW)

☐ **SELF PAYMENT**

◯ Bill Patient For Laboratory Testing

☐ **INSTITUTIONAL BILLING**

Institution Name | Institution Code | Institution Contact Name | Institution Phone | Institution Contact Email

☐ **INSURANCE**

☐ Do Not Perform Test Until Patient is Aware of Out-Of-Pocket Costs (excludes prenatal testing)

REQUIRED ITEMS
1. Copy of the Front/Back of Insurance Card(s)
2. ICD10 Diagnosis Code(s)
3. Name of Ordering Physician
4. Insured Signature of Authorization

Name of Insured | Insured Date of Birth (MM/DD/YY) | Address of Insured

Patient's Relationship to Insured | Phone of Insured | City | State | Zip

Primary Insurance Co. Name | Primary Insurance Co. Phone | Primary Member Policy # | Primary Member Group #

Secondary Insurance Co. Name | Secondary Insurance Co. Phone | Secondary Member Policy # | Secondary Member Group #

By signing below, I hereby authorize Baylor Genetics to provide my designated insurance carrier any information necessary, including test results, for processing my insurance claim. I also authorize benefits to be payable exclusively to Baylor Genetics. I understand that my insurance carrier may not approve or reimburse my medical genetic services in full or any portion thereof, due to a variety of reasons, including, but not limited to: the contract status of my insurance provider with Baylor Genetics, usual and customary rate limits, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand that I am responsible for any co-pay, co-insurance, and unmet deductible that the insurance policy dictates. I understand that I am responsible for any amounts not paid by my insurance carrier for reasons including, but not limited to,non-covered and non-authorized services. I understand that I am responsible for sending Baylor Genetics. any and all payments that I receive directly from my insurance company in payment for this test. Please note that Medicare does not cover routine screening tests.

Patient's Name | Patient's Signature | Date

STATEMENT OF MEDICAL NECESSITY (REQUIRED)

This test is medically necessary for the risk assessment, diagnosis, or detection of a disease, illness, impairment, symptom, syndrome, or disorder. The results will determine my patient's medical management and treatment decisions. The person listed as the Ordering Physician is authorized by law to order the test(s) requested herein. I confirm that I have provided genetic testing information to the patient and they have consented to genetic testing.

Physician's Printed Name | Physician's Signature | Date

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Patient Last Name _____ Patient First Name _____ MI _____ Date of Birth (MM/DD/YY) ___/___/___ Biological Sex _____

ETHNICITY

- ◯ African American
- ◯ Ashkenazi Jewish
- ◯ East Asian (China, Japan, Korea)
- ◯ Finnish
- ◯ French Canadian
- ◯ Hispanic American
- ◯ Mennonite
- ◯ Middle Eastern (Saudi Arabia, Qatar, Iraq, Turkey)
- ◯ Native American
- ◯ Northern European Caucasian (Scandinavian, UK, Germany)
- ◯ Pacific Islander (Philippines, Micronesia, Malaysia, Indonesia)
- ◯ South Asian (India, Pakistan)
- ◯ Southeast Asian (Vietnam, Cambodia, Thailand)
- ◯ Southern European Caucasian (Spain, Italy, Greece)
- ◯ Other (Specify) _____

INDICATION FOR TESTING (REQUIRED)

◆ CMA OPTIONS

- ☐ Autism Spectrum
- ☐ Developmental Delay
- ☐ Dysmorphic Features
- ☐ Other (Specify): _____
- ☐ Failure to Thrive
- ☐ Multiple Congenital Anomalies
- ☐ Seizure Disorder

◆ CHROMOSOME/FISH OPTIONS

- ☐ Autosomal Trisomies
- ☐ Ambiguous Genitalia
- ☐ Fetal Demise
- ☐ Other (Specify): _____
- ☐ Infertility
- ☐ Klinefelter/Turner
- ☐ Multiple Miscarriages

ICD10 Diagnosis Code(s): _____

SAMPLE

Date of Collection (MM/DD/YY) ___/___/___

◆ SAMPLE TYPE

- ◯ Blood in EDTA tube (purple top)
- ◯ Blood in Sodium Heparin tube (green top)
- ◯ Cord Blood

CHROMOSOMAL MICROARRAY ANALYSIS (CMA) TESTS

Products of Conception (POC) and fetal tissue tests should be requested using the "Cytogenetics - Products of Conception Requisition", which can be found at www.BMGL.com.

TEST CODE	TEST NAME	SAMPLE TYPE *	SPECIFY GENE OF INTEREST	SPECIFY REGION OF INTEREST
☐ 8665	Chromosomal Microarray Analysis (CMA) - HR + SNP Screen (Comprehensive)	BE + BH		
☐ 8655	Chromosomal Microarray Analysis (CMA) - HR	BE + BH		
☐ 8650	Chromosomal Microarray Analysis (CMA) - CytoScan HD SNP Array	BE + BH		

PARENTAL STUDIES RECOMMENDED IN CHILD'S CMA REPORT (attach copy)

☐ MOTHER: _____ (First, MI, Last) ___/___/___ (Date of Birth (MM/DD/YY)) ◯ ASYMPTOMATIC ◯ SYMPTOMATIC (attach summary of findings)

☐ FATHER: _____ (First, MI, Last) ___/___/___ (Date of Birth (MM/DD/YY)) ◯ ASYMPTOMATIC ◯ SYMPTOMATIC (attach summary of findings)

SAMPLE SPECIFICATIONS TABLE

ABBREVIATION	SAMPLE NAME	RECOMMENDED AMOUNT (2 yrs - Adult)	RECOMMENDED AMOUNT (Newborn - 2 yrs)	SHIPPING INSTRUCTIONS	SPECIAL NOTES
BE	Blood in EDTA tube (purple-top)	3 - 5 cc	2 - 3 cc	Ship at room temperature in an insulated container by overnight courier. Do not heat or freeze.	
BH	Blood in Sodium Heparin tube (green top)	3 - 5 cc	1 - 2 cc	Ship at room temperature in an insulated container by overnight courier. Do not heat or freeze.	
CB	Cord Blood	N/A	1 - 2 cc	Ship at room temperature in an insulated container by overnight courier. Do not heat or freeze.	Ensure properly labeled. Also send 3 cc of maternal blood in properly labeled EDTA tube for MCC studies at no charge as needed.

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POSTNATAL CMA / CYTOGENETICS REQUISITION

Patient Last Name _____ Patient First Name _____ MI _____ Date of Birth (MM/DD/YY) ____/____/____ Biological Sex _____

CYTOGENETIC TESTS

Products of Conception (POC) and fetal tissue tests should be requested using the "Cytogenetics - Products of Conception Requisition", which can be found at BMGL.com.

TEST CODE	TEST NAME	SAMPLE TYPE *
☐ 8600	Chromosome Analysis	BH
☐ 8480	FISH for SRY - Related Phenotypes (Metaphase & Interphase Cells) **	BH

** Testing on metaphase cells requires cell culturing.

NOTE: The following tests (8425 and 8426) REQUIRE selecting an accompanying test (8665, 8655, or 8600)

TEST CODE	TEST NAME	SAMPLE TYPE *
☐ 8425	Rapid FISH - AneuVysion (+13/+18/+21/X/Y) (Interphase cells ONLY)	BH
☐ 8426	Rapid FISH - Sex Chromosomes (X/SRY) (Interphase cells ONLY)	BH

+

TEST CODE	TEST NAME	SAMPLE TYPE *
☐ 8665	Chromosomal Microarray Analysis (CMA) - HR + SNP Screen (Comprehensive)	BE and BH
☐ 8655	Chromosomal Microarray Analysis (CMA) - HR	BE and BH
☐ 8600	Chromosome Analysis	BH

FISH STUDIES

Products of Conception (POC) and fetal tissue tests should be requested using the "Cytogenetics - Products of Conception Requisition", which can be found at BMGL.com.

TEST CODE	TEST NAME	SAMPLE TYPE *	TEST CODE	TEST NAME	SAMPLE TYPE *
☐ 8456	1p36 Deletion Syndrome	BH	☐ 8471	Miller-Dieker Syndrome	BH
☐ 8457	Adrenal Hypoplasia Congenita	BH	☐ 8435	Multiple Exostoses (*EXT1* and *EXT2*) Panel	BH
☐ 8459	Angelman Syndrome	BH	☐ 8472	Multiple Exostoses Type I (*EXT1*)	BH
☐ 8460	Beckwith-Wiedeman Syndrome	BH	☐ 8473	Mulitple Exostoses Type II (*EXT2* and *ALX4*)	BH
☐ 8462	Charcot-Marie-Tooth Neuropathy Type 1A	BH	☐ 8474	Neurofibromatosis Type I	BH
☐ 8464	Cri-Du-Chat Syndrome	BH	☐ 8476	Prader-Willi Syndrome	BH
☐ 8440	DiGeorge/Velocardiofacial Syndrome (22q and 10p) Panel	BH	☐ 8477	Rubinstein-Taybi Syndrome	BH
☐ 8486	DiGeorge/Velocardiofacial Syndrome Type I (22q)	BH	☐ 8478	Smith-Magenis Syndrome	BH
☐ 8465	DiGeorge/Velocardiofacial Syndrome Type II (10p)	BH	☐ 8479	Sotos Syndrome	BH
☐ 8466	Glycerol Kinase Deficiency	BH	☐ 8480	SRY-Related Phenotypes	BH
☐ 8467	Hereditary Neuropathy w/ Liability to Pressure Palsies	BH	☐ 8482	Trichorhinophalangeal Syndrome Type I	BH
☐ 8458	JAG1-Related Alagille Syndrome	BH	☐ 8450	WAGR (*WT1* and *PAX6*) Panel	BH
☐ 8469	Kallmann Syndrome Type I	BH	☐ 8483	Williams Syndrome	BH
☐ 8430	Langer-Giedion Syndrome (*EXT1* and *TRPS1*)	BH	☐ 8455	Wilms Tumor (*WT1*)	BH
☐ 8468	LIS1-Associated Lissencephaly	BH	☐ 8484	Wolf-Hirschhorn Syndrome	BH
☐ 8470	Microphthalmia w/ Linear Skin Lesions (MLS/MIDAS)	BH	☐ 8485	X-Linked Ichthyosis	BH

* Refer to Sample Specifications Table (page 2)