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

CYTOGENETICS - PRODUCTS OF CONCEPTION 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**

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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Fetus of: _____ (Patient Last Name) _____ (Patient First Name) _____ (MI) ___/___/___ (Maternal 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)

- ☐ Recurrent Pregnancy Loss (N96)
- ☐ Maternal Care for Intrauterine Death, Not Applicable or Unspecified (O36.4XX0)
- ☐ Encounter for Elective Termination of Pregnancy (Z33.2)
- ☐ Other (Specify ICD-10 code): _____
- ☐ Missed Abortion (O02.1)
- ☐ Blighted Ovum and Nonhydatidiform Mole (O02.0)
- ☐ Other Abnormal Products of Conception (O02.89)

◆ GESTATIONAL INFORMATION

Date of Pregnancy Loss (MM/DD/YY) ___/___/___

Gestational Age at Loss (weeks) _____

Type of Pregnancy ☐ Singleton Pregnancy ☐ Multiple Gestation

Was an Egg Donor Used During This Pregnancy? ◯ YES ◯ NO

CYTOGENETIC TESTS

☐ 8800 Chromosomes (Tissue)

◆ **SAMPLE TYPE**

- ◯ Fresh Tissue
  - ◯ POC ◯ Villi

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

☐ 8639 CMA - POC

◆ **SAMPLE TYPE**

- ◯ Fresh Tissue:
  - ◯ POC ◯ Villi
- ◯ Frozen Tissue
- ◯ Autopsy Material
- ◯ FFPE Slides #: _____
- ◯ FFPE Blocks #: _____

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

☐ **Maternal Cell Contamination Studies**
(RECOMMENDED For Test Code 8639)

MOTHER: _____ (First, MI, Last) ___/___/___ (Date of Birth (MM/DD/YY))

☐ Blood Sample (5 cc in EDTA Tube) collected from Biological Mother

NOTE: Fresh tissue samples should be submitted in sterile media whenever possible (see BMGL.com for specific handling instructions).