Requisition Form – Pediatric Analysis

CombiMatrix

Client Information

Referring Physician__________________________ NPI______________________

Ordering Physician__________________________ NPI______________________

Genetic Counselor/Clinical Contact ____

Tel ____________________________ Fax ____________________________

Email____

Authorized Signature ____

Patient Information

Last Name________________________ First Name________________________

DOB ____________________________ Gender ____________________________

Street Address____

City, State, Zip ____

Tel ____

Email____

Medical Record Number ____

Billing Information

Bill: ❑ Institution ❑ Insurance ❑ Medicare ❑ Medicaid ❑ Patient

Insurance Information ❑ See attached

Insured Information Name ______________________________________

Relationship to Patient ❑ Self ❑ Spouse ❑ Child ❑ Other:________________

Primary Insurance Co.___________________ Authorization # ___________________

Billing Address ______________________ Insured # _________________________

Billing City, State, Zip___________________ Group #_________________________

Secondary Insurance Co. ________________ Authorization # ___________________

Billing Address ______________________ Insured # _________________________

Billing City, State, Zip ___________________ Group #_________________________

For Patient Bill cases, complete and submit "Self-Pay Testing Option" form. Testing will not be performed unless a completed form is received.

Patient Authorization/Assignment
I authorize CombiMatrix to obtain and release relevant medical and other information as needed to submit claims to Medicaid, Medicare, or Medicare Supplemental for laboratory services CombiMatrix provides to me. I assign insurance benefits to CombiMatrix and acknowledge that charges not covered by my insurance, including any applicable copayments or deductibles, are my responsibility, and I agree to pay them.

____
Print Name of Patient or Guardian

____
Signature of Patient or Guardian Date (mm/dd/yyyy)

Clinical / Specimen Information

Collection Date ______________________________ # Tubes_________________

Specimen ID #(s)____

Sample Type

❑ Whole blood - EDTA (purple top)

❑ Whole blood - NaHep (green top)

❑ Extracted DNA ____________________

❑ Tissue/cultured fibroblasts

❑ Buccal swab (microarray only)

❑ Other ______________________

Indications for Testing

Please provide as much detail as possible about the patient's phenotype. Not only is this information utilized in the result interpretation process, it also assists with further classification of copy number variations that are currently thought to represent variants of uncertain clinical significance (VOUS). Please indicate the patient's developmental status below, and then specify the phenotypic features on the Pediatric Phenotypic Checklist.

Developmental Status

❑ Autistic disorder (F84.0)

❑ Development disorder of speech & language, unspecified (F80.9)

❑ Specific developmental disorder of motor function (F82)

❑ Delayed milestone in childhood (R62.0)

❑ Developmental disorder of scholastic skills, unspecified (F81.9)

❑ Intellectual disability ❑ Mild (F70) ❑ Moderate (F71) ❑ Severe (F72)

❑ Other ___________________________________ ❑ ICD-10 _______________

Clinical Phenotype

Please indicate abnormalities on the Pediatric Phenotypic Checklist provided with the CombiMatrix kits.

Test Selections

Developmental Disorders

❑ Chromosomal microarray analysis (with confirmation FISH when indicated)
Please note that follow-up testing may require a pheripheral blood sample.

❑ Karyotype on peripheral blood sample (cannot be performed on buccal swab)
If microarray analysis is not being performed reflex to FISH for 22q11.2? ❑ Yes ❑ No

❑ Fragile X

Parental/ Familial Studies

For parental or family studies, please complete the Parental and Family Studies Test Requisition form. You can access this and other forms on our website at: www.combimatrix.com/providers/forms.

Special Instructions/Additional Testing Requests

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