UHealth University of Miami Health System Pathology

UNIVERSITY OF MIAMI
MILLER SCHOOL of MEDICINE

University of Miami Medical Laboratories

CYTOGENETICS & MOLECULAR DIAGNOSTICS LABORATORY

CMDL REQUEST FORM 3

Accession No. _____
Received by _____
Date_____Time _____ am/pm
Amount of Sample _____
Condition of Sample _____

ATTENTION HEALTH CARE PROVIDERS

Medical Necessity: Federal regulators require that only tests that are necessary for diagnosis and treatment of a patient's condition be ordered. ICD-9 Code is **required** to prove medical necessity of outpatients. Dr.'s name, phone number and ICD-9 Code are **absolutely required.**

PATIENT INFO: PLEASE PRINT ALL OF THE FOLLOWING INFORMATION

Last Name:_____ First Name:_____
Address:_____
City:_____ State:_____ Zip:_____
SS#: _____ - _____ - _____
Date of Birth: _____ /_____ /_____ Sex: M ❒ F ❒

Client. No. Telephone

Medical Record # _____

ATTENDING PHYSICIAN INFORMATION (PLEASE PRINT LEGIBLY)

Test Order Date: _____ /_____ /_____Time Ordered:_____ am / pm
Ordering M.D. **Name:**_____/**Name:**_____
Ordering M.D. **Signature:**_____
Ordering M.D. **NPI #:** _____ **Beeper/Ph:**_____
Fax:_____Hosp./Lab Name: _____
Address: _____
City:_____ State:_____Zip:_____

SPECIMEN INFORMATION

Collection Date: _____/_____/_____ Time:_____ am / pm
Collected By: _____
Specimen Type:
❒ Amniotic Fluid (GA:_____)
❒ Chorionic Villi (GA:_____)
❒ Peripheral Blood
❒ Other_____
❒ Skin Biopsy (Specify Site_____)
❒ Products of Conception/Fetal tissue (Specify Site_____)
❒ Other_____

CLINICAL INFORMATION

❒ Abnormal MSS Triple Screen ❒ Autism ❒ Down Syndrome ❒ Mental Retardation ❒ Trisomy 18
❒ Abnormal Ultrasound ❒ Congenital Anomalies ❒ Dysmorphic Features ❒ Microdeletion Syndrome ❒ Turner Syndrome
❒ Advance maternal Age ❒ Developmental Delay ❒ Klinefelter Syndrome ❒ Trisomy 13 ❒ Other: _____

PATIENT INSURANCE INFORMATION (IF APPLICABLE)

INSURED: _____ ❒ HMO ❒ PPO ❒ POS Insurance Co.: _____
Authorization # (if required): _____ Policy # _____ Medicare / Medicaid #: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: ( ) _____ Cell: ( ) _____ Fax: ( ) _____
Relationship to Insured: _____ Bill Credit Card#: _____ exp. _____

TESTS FOR DEVELOPMENTAL DISORDERS

1601 NW 12th Avenue, MCCD 7050, Miami, Florida 33136 / Ph. (305) 243-6870 • Fax (305) 243-3805 • Toll Free: (800) VIA-CYTO

✔	TEST CODE	CLINICAL INDICATION	TEST DESCRIPTION	PROBE/CHROMOSOME REGION/GENE	CPT	ICD9
	1004	Chromosomal Abnormalities	Routine Chromosome Study (Peripheral blood)	Chromosomes 1~22,X/Y	88230x1, 88261x1, 88280x1, 88291	
	1002	Chromosomal Abnormalities	Routine Chromosome Study (Amniotic fluid)	Chromosomes 1~22,X/Y	88235x1, 88267x1, 88280x1, 88291	
	1010	Chromosomal Abnormalities	Routine Chromosome Study (Solid Tissue /POC)	Chromosomes 1~22,X/Y	88233x1, 88261x1, 88280x1, 88291	
	1001	Common aneuploidies (Chromosomes 13, 18, 21, X/Y)	FISH	Aneuvysion Kit: LSI 13, CEP18,LSI 21, CEPX, CEPY	88368x5	
	1022	Developmental delay, autism, congenital anomalies, , mental retardation, malformations, uniparental disomies	Cytogenomic array	180K CGH + SNP	81229	
	1003		Cell Culture, amniotic fluid or CVS		88235x1	
	1005		Cell Culture, peripheral blood		88230x1	
	1011		Cell Culture,solid tissue/POC		88233x1	
	2003	Di-George/Velocardiofacial(VCF)	FISH	TUPLE 1/ 22q11.2	88271x1, 88273x1, 88291	
	2004	Gonadal Dysgenesis(XY Female/XX Male)	FISH	CEP X, SRY/Xp11.1-q11.1, Yp11.3	88271x2, 88273x1, 88291	
	3001	Prenatal Screening	Amniotic Fluid AFP	Send out test	82106	
	3002	Prenatal Screening	Amniotic Fluid, Acetylcholinesterase	Send out test	82013	
			Other			

(Please note that cell culture will be added if FISH for microdeletion syndrome is ordered without ordering chromosome study)

REFER TO LABORATORY COMPENDIUM FOR SPECIMEN INFORMATION. LAB TESTING WILL NOT BE PERFORMED IF LACKING COMPLETE INFORMATION.

ATTENDING PHYSICIAN ASSUMES RESPONSIBILITY FOR OBTAINING APPROPRIATE INFORMED CONSENT FOR GENETIC TESTING/COUNSELING.

FL AHCA: 8000001842	Provider: L9260	
CLIA: 10D0279395	External Billing Area: PPSEC 1307	
Medicare: L9260	Internal Billing Area: PPSIC 1308	
Medicaid: 05-7829100	Tax ID No.: 59-2695890	Facility: PSS

I hereby authorize this request for professional services to be rendered and billed by the above captioned laboratory. I further authorize the release of any medical information required by insurance carrier or MEDICAID / MEDICARE carrier.

Distribution: White—Billing Yellow—Lab Pink—Client / Rev. 04/11

Signature :