05820-1. MARQUETTE GENERAL HOSPITAL
ATTN: LABORATORY
420 W MAGNETIC

MARQUETTE MI 498552711 9062289440

# SPECIALTY LABORATORIES

2211 Michigan Avenue
Santa Monica, CA 90404 800- 421- 4449

☐ Client Account Billing ☐ Patient Billing ☐ Insurance ☐ Medicaid/Cal Billing
☐ Medicare – Hospitals please see "Medicare Hospital Bundling Rules" on back of form

| PATIENT NAME (Last) (First) (MI) | Sex M F | PATIENT ADDRESS (Street Address, Apt #) | | | |
|---|---|---|---|---|---|
| DATE OF BIRTH / AGE / RACE / PATIENT SOC SEC # | | (City) | (State) | (Zip) | Phone |
| PATIENT ID # / Specimen ID # / DRAW DATE / DRAW TIME AM PM | | INSURANCE NAME — Please attach copy of card | | | |
| PHYSICIAN NAME (Last) (First) (MI) / UPIN# | | (Address) | (City) | (State) | (Zip) |
| CLIENT REPORT NOTE (25 Character Max) / PATIENT INFO/CLINICAL DIAGNOSIS | | SUBSCRIBER NAME | RELATIONSHIP ☐ Self ☐ Spouse ☐ Dependent | | |
| *Specialty* PREVIOUS SPECIMEN # | | GROUP POLICY # | SUBSCRIBER/MEDICARE/MEDICAID # | | |

**Patient Signature** Requested for Third Party Billing

I authorize release of any medical or other information necessary to process my claim and authorize payment of my medical benefits to Specialty Laboratories.

Signature Date

**ABN (Advance Beneficiary Notice Medicare)**

1. Do any of the tests you ordered require Advance Beneficiary Notification? yes ☐ no ☐ *If "no", no further action required.*
2. Is there a signed ABN? yes ☐ no ☐ *If yes, please attach signed ABN form*

| Call/Fax Results to: | Specimen Type/Source | Temp (A/R/F) | # Tubes | Total Tests |
|---|---|---|---|---|
| | | | | |

## Molecular Genetics Testing Requisition

### INFORMATION REQUIRED FOR TEST RESULT INTERPRETATION

☐ **New York Clients, please check here to indicate Informed Consent form has been obtained.**

**REQUIRED INFORMATION:** Client Services: Fax 310-586-7275 Phone- 800-421-4449

Contact physician:

Physician phone:

Physician fax:

Differential diagnosis / Clinical question(s):

**Ethnic Background of Origin**
*(For CF testing only; please check one box only)*

☐ Caucasian, European
☐ Caucasian, Ashkenazi Jewish
☐ Hispanic ☐ Black ☐ Asian
☐ Mixed Ethnic Origin, please specify: _____
☐ Other: _____

**Is There a Family History of Cystic Fibrosis or Fragile X?**

☐ **Yes** ☐ **No**

If yes, please provide details:

_____
_____
_____

**Test Code Test Name ICD-9 code**

**Carrier & Diagnostic testing:**
☐ 5356 Cystic Fibrosis GenotypR™: Carrier Study (Adult)
☐ 5357 Cystic Fibrosis GenotypR™: Diagnostic (Adult/Neonate)
☐ 5362 Fragile X DNA Probe Analysis (Adult/Neonate)

**Prenatal testing:**
☐ 3111 Alpha-Fetoprotein Prenatal, Amniotic Fluid
☐ 5822 Chromosome Analysis, Amniotic Fluid
☐ 5358 Cystic Fibrosis GenotypR™ : Prenatal Diagnosis
☐ 5363 Fragile X DNA Analysis, Prenatal Diagnosis

**Chromosome Analysis:**
☐ 5814 Blood Disorders, Congenital

**Specimen Type**

**For Carrier and Diagnostic Studies:**
☐ Whole blood – 5.0 (3.0) mL ACD or EDTA

**For Prenatal Diagnostic Studies:**
*Mother's blood (5.0mL ACD or EDTA) should accompany all prenatal specimens.*
☐ Amniotic fluid for culture - 10 mL
☐ Cultured amniotic fluid cells - one confluent T25
☐ Chorionic villus sample - 10 mg of CVS, dissected
☐ Other: _____

**For Chromosome Analysis:**
☐ Whole blood – 10.0 (2.0) mL Sodium Heparin

*Do not refrigerate or freeze specimens. Ship immediately within 24 hours of collection.*

NOTE: If the required clinical information is not provided, we will contact the referring physician by fax requesting the needed details. If after three business days we are unable to obtain this information, the test result will be released without an interpretation.

For complete listing see the *Specialty* Directory of Services, or website www.specialtylabs.com

CF R11313 10/2001

*Only medically necessary tests (based on specific patient diagnosis and treatment) should be ordered. Screening tests will generally not be reimbursed by third party carriers.*