Genetics Laboratory Department of Pediatrics
Molecular Genetics Requisition

Patient Sticker Here

Basic Sciences & Education Bldg
941 Stanton L. Young Blvd. 224
Oklahoma City, OK 73104
Phone: 405-271-3589
Fax: 405-271-7117
After hours phone: 405-496-9514
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COMPLETE A BILLING INFORMATION FORM FOR ALL OUTPATIENTS AND ATTACH TO THIS FORM.

REFERRING PHYSICIAN/FACILITY

Requesting Physician____

Physician's Phone_(____)___________Cell/Pager_(___)_______________

Clinic/Hospital____

Phone_(___)________________ Fax results to_(____)_________________

Preliminary and final reports will be faxed to the number listed on the requisition form. Failure to list a fax number will delay receipt of patient results.

Genetic Counselor____________________Phone_(____)_______________

Cell/Pager_(____)____________________ Fax_(____)________________

PATIENT AND BILLING INFORMATION

Patient Name (last,first,m.)_____________________________________

DOB___________ SSN_______________ MRN_______________

Sex: Male Female Ambiguous ☐ Inpatient ☐ Outpatient

Patient's Address____

City___________________________ State_______ Zip Code__________

Insurance Co._____________________ Auth/Referral #________________

(Provide a copy front and back of insurance card)

I consent to have the following test(s) performed. I authorize my insurance company to pay these providers for services filed on my behalf. I authorize release of information necessary to secure payment from my insurance. I understand that I am responsible for all charges incurred, and I agree to pay for services as they are provided and pay promptly upon receipt of a statement. (Outpatients only need to sign below.)

____

Patient/Guardian Signature Date

SPECIMEN/CLINICAL INFORMATION

Diagnosis/Clinical Findings/Family History____

You may also list ICD-9 codes

Date Specimen Collected____________________ Time__________

SPECIMEN TYPES & COLLECTION REQUIREMENTS

☐ **Peripheral Blood**
3-5 cc in a large EDTA tube (purple top),mix well. Specimen must be kept at room temperature or cooler, do not freeze.

☐ **Amniotic Fluid Do Not Transport Specimen in Syringes!**
Collect 5-10 cc of fluid and transfer to sterile centrifuge tubes. Keep specimen cool but do not freeze. **Gestational age by:**
ultrasound_________ or LMP__________
Gravida__ __ Para__ __ __ __

☐ **Buccal Swab (See instructions for collecting specimen)**
Collect 3 specimens with nylon brushes. Rub the tip of the brush firmly along the inside of the cheek for 10-15 seconds, then place the cap on the brush.Keep at room temperature.
This specimen type cannot be used for Fragile X studies.

☐ **Other** (please specify)__________________________
Contact laboratory before sending specimen.

TEST INFORMATION

Please Select One of the Following Studies:

☐ Cystic Fibrosis
☐ Fragile X study
☐ MCAD (Medium-Chain-Acyl-CoA-Dehydrogenase deficiency)
☐ Prader-Willi syndrome Methylation
☐ Angelman syndrome Methylation
☐ Uniparental disomy (UPD) chromosome_______
☐ Sickle Cell disease
☐ Y chromosome deletion
☐ Micro-Array
☐ Huntington Disease (PCR/Southern blot)

ADDITIONAL REPORT

Physician/Facility_____________________________________

Phone_(___)__________________ Fax_(___)______________

Address____

____

☐ OU Medical Center Clinical Laboratory Referral

GENETICS LABORATORY USE ONLY

Laboratory Number______________________________________

Date & Time of Pick-Up/Delivery__________________________

Location____

Initials_________ Check-in__________ Entered in Database_____

Additional Specimen(s)sent for patient______________

Previous Lab Number____________________________________