Children's Mercy KANSAS CITY

Dept of Pathology & Laboratory Medicine
2401 Gillham Rd
Kansas City, MO 64108
(816) 234-3835

Clinical Genetics & Genomics Requisition

CLEAR FORM

Patient's Name: Last	First	Middle	Birthdate	Gender

Address	City, State, Zip	Phone

Client/Practice Name	Address	City, State, Zip	Phone
Ordering Provider	**Clinician Signature**		**Fax**
Genetic Counselor Name	**Genetic Counselor Phone**		

MEDICAL NECESSITY REGULATIONS: at the government's request, the Lab would like to remind all physicians that when ordering tests expected to be paid under federal health care programs, such as Medicare and Medicaid, the testing must meet the following conditions: (1) included as covered services, (2) reasonable, (3) medically necessary for the treatment and diagnosis of the patient and (4) not for screening purposes.

If numeric diagnosis code(s) and an authorization number are not provided as appropriate, the laboratory reserves the right to refuse service.

Billing: ☐**Practice/Client** ☐**Patient self-pay** ☐**Patient Insurance - Attach copy of card (both side)**	**Patient is:** ☐**Child** ☐**Self** ☐**Spouse** ☐**Other (specify)**
Subscriber: Last, First, MI	**Primary: carrier & policy number**
Employer	**Secondary: carrier & policy number**

Insurance Authorization

☐ Initiated/pending or Authorization Number: Valid Date(s):

By submitting this requisition, the ordering physician attests:	**Reason for testing**
1. **All requested laboratory tests are medically necessary** 2. **Insurance preauthorization has been obtained if required by the payor**	

Specimen Requirements: See the Test Catalog For best results, send specimens the same day as collection If necessary to hold specimen overnight, keep at room temp – DO NOT FREEZE	**Additional Diagnosis/Indication information** ☐ Targeted variant/Familial testing ☐ Other ☐ Diagnostic/Symptomatic Patient's Symptoms/Pedigree - Please attach documentation/records or add information on the next page

Specimen Information

Collection date	Collection time	Collected by

Specimen(s) Submitted

- ☐ ORAcollect
- ☐ Blood ☐peripheral ☐cord
- ☐ Bone Marrow
- ☐ Skin/Tissue
- ☐ Urine
- ☐ Other, specify:
- ☐ DNA | Must be isolated in a CLIA or equivalent laboratory; by checking this box the ordering provider is attesting to DNA extraction in an appropriately qualified laboratory

Orders

Cytogenetic

- ☐ Chromosome Analysis, Routine
- ☐ Chromosome Analysis, High Resolution
- ☐ Cell Culture & Cryopreservation – Skin/Tissue only
- ☐ FISH, specify probes:

DNA

- ☐ Angelman Syndrome
- ☐ Ataxia panel (ATXN1, ATXN2, ATXN3, ATXN7, CACNA1A, FXN)
- ☐ Beckwith-Wiedemann Syndrome
- ☐ Custom Targeted Sequencing; specify below
- ☐ DNA isolation/storage
- ☐ DMPK Repeat Analysis
- ☐ Fragile X Syndrome (FMR1)
- ☐ kiddose™ PGx
- ☐ LHON (MT-ND1, MT-ND4, MT-ND6)
- ☐ Microarray Analysis Copy Number + SNP, Constitutional
- ☐ Mitochondrial Genome
- ☐ Neonatal Hypotonia panel (SMA, DMPK, PWS)
- ☐ NGS, Symptom Driven Long Read Exome/Genome – contact the Lab
- ☐ NGS, Custom Panel (2–50 genes); list below
- ☐ NGS, Single gene; list below
- ☐ NGS, Symptom-driven exome sequencing; list below
- ☐ Optical Genome Mapping (OGM)
- ☐ Prader Willi Syndrome
- ☐ qPCR Parent confirmation
- ☐ qPCR Other family member
- ☐ Russell-Silver Syndrome
- ☐ Spinal Muscular Atrophy (SMN1/2 deletion)
- ☐ Thrombosis panel (FV/PT)
- ☐ X-chromosome inactivation

Additional information