Children's Mercy KANSAS CITY

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

Clinical Genetics & Genomics
Prenatal & Pregnancy Loss 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: 1. All requested laboratory tests are medically necessary 2. Insurance preauthorization has been obtained if required by the payor	Reason for testing

Specimen Requirements: See the Test Catalog

For best results, send specimen same day as collection

If necessary to hold specimen overnight, keep at room temp – DO NOT FREEZE

Additional Diagnosis/Indication information

GA by U/S: _____weeks _____days
Estimated Date of Delivery by U/S: _____
GA by dates: _____weeks _____days
Fetal sex: ☐male ☐female ☐unknown
Donor sperm ☐ Donor egg ☐

Specimen Information & Orders

Collection date **Collection time** **Collected by**

Prenatal

Specimen submitted ☐ Amniotic Fluid, amount_____ ☐ CVS amount _____

Test Requested

☐ Chromosome Analysis ☐ AFAFP ☐ AChE ☐ FISH Prenatal Panel (13, 18, 21, X & Y) ☐ Other FISH _____
☐ Targeted Microarray* ☐ Prenatal Symptom-driven exome/genome*
☐ Targeted Sequence Analysis* ☐ Custom NGS Panel* _____
*Requires a maternal blood sample for Maternal Cell Contamination ☐ Other test_____

Pregnancy Loss

Specimen submitted ☐ Fetal Tissue, source_____ ☐ Villi ☐ Other_____

Test Requested

☐ Chromosome Analysis ☐ FISH, specify_____
☐ Microarray | Please also provide a maternal blood sample for Maternal Cell Contamination
☐ Other test_____

Maternal blood ☐ Maternal Cell Contamination