University of Nebraska Medical Center
REGIONAL PATHOLOGY SERVICES

Regional Pathology Services
University of Nebraska Medical Center
981180 Nebraska Medical Center
Omaha, Nebraska 68198-1180
www.reglab.org

Toll Free: 1.800.334.0459
Phone: 402.559.6420
Fax: 402.559.9497

POSTNATAL Test Request Form

A. PATIENT IDENTIFICATION

NAME: _____ DOB: _____ MR#: _____ BIOLOGICAL SEX: ☐ Female ☐ Male

PHONE#: _____ ADDRESS: _____ CITY/ST/ZIP: _____

B. SPECIMEN INFORMATION

- Access specimen requirements at: https://www.reglab.org/services/human-genetics
- Ship specimens immediately - avoid extreme temperatures. Testing is most successful when performed on samples received within 24 hours of collection. If immediate shipment is not possible, contact us and store at room temperature.

NOTES:

COLLECTION DATE: _____ COLLECTION TIME: _____

SAMPLE TYPE: ☐ Blood ☐ Buccal mucosa* ☐ DNA ☐ Tissue / Skin

PATIENT CONSENT: ☐ Check this box if your patient does not wish to have their specimen stored. Consent is implied if box is left unchecked.

*FISH testing performed on a buccal specimen requires collection using a special kit that can be requested by calling the laboratory.

C. TEST SELECTION

- ☐ **Chromosome Analysis**
- ☐ **Chromosome Breakage for Fanconi anemia (SPPRB to Fairview)**
- ☐ **FISH - Aneuploidy** [13, 18, 21, X, Y]
- ☐ **FISH - 22q11.2**
- ☐ **FISH -** [specify]: _____
- ☐ **Fragile X** **performed & reported by Nebraska Medicine Molecular Diagnostic Lab*
- ☐ **Male Infertility PANEL** [includes both tests listed below]
  - ☐ Chromosome Analysis ONLY
  - ☐ Y Chromosome Microdeletion (YCMD) ONLY
- ☐ **Methylation Analysis* - Chromosome 15 (SPPRB/O to ARUP)** [Prader-Willi syndrome, Angelman syndrome]
- ☐ **Microarray Analysis - High Density SNP** with confirmatory studies, if needed

OTHER TESTING

- ☐ **Cell Culture and Cryopreservation only**
- ☐ **DNA Extraction and Cryopreservation only**
- ☐ **Other -** [specify]:

SPECIAL INSTRUCTIONS:

D. CLINICAL INFORMATION

- Attach family history, pedigree, or other clinical information, if available

ANCESTRY / FAMILY HISTORY:

- ☐ African American
- ☐ Asian
- ☐ Latin American/Caribbean
- ☐ Native American
- ☐ European
- ☐ Other:
- ☐ Ashkenazi Jewish
- ☐ Central/Eastern European
- ☐ Middle Eastern
- ☐ Western/Northern

CLINICAL INFORMATION:

INDICATIONS FOR TESTING:

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E. BILLING

☐ CLIENT BILLING

» *Existing clients, please provide information below to be invoiced.*

» *To set up a new client billed account call 402-559-6420 and ask for an account manager.*

FACILITY: _____

BILLING CONTACT: _____

PHONE: _____

PO#: _____

INSURANCE / PATIENT BILLING » Requires patient signed statement of responsibility, below.

» *Include an enlarged copy of both sides of the insurance card; Call 402-559-8359 with authorization questions.*

☐ Medicaid ☐ Medicaid pending ☐ Medicare » *An ABN may be required*

☐ Insurance approved: *AUTH#:* _____ *VALID DATE:* _____ *EXP DATE:* _____

☐ Preauthorization service requested (testing will be placed on hold until authorization is complete)

» *Provide patient contact info -* *PHONE#:* _____ *EMAIL:* _____

ICD CODE(S): _____

☐ Patient insurance » *If policy holder is different from patient, provide:* *NAME* _____ *DOB* _____

☐ Self-pay (patient billed after testing is completed)

☐ Pre-pay (testing begins once full payment is made) » *RESPONSIBLE PARTY NAME:* _____

ADDRESS: _____ *PHONE#:* _____ *EMAIL:* _____

CREDIT CARD#: _____ *EXP DATE:* _____ *CVV:* _____

STATEMENT OF FINANCIAL RESPONSIBILITY - My signature below indicates that I understand that I am accepting financial responsibility for all fees associated with this genetic testing including but not limited to co-pays, co-insurance, and unmet deductibles that the insurance policy dictates. I understand that I may also be responsible for any amounts not paid by my insurance carrier for reasons including but not limited to non-covered and non-authorized services. I authorize the Human Genetics Laboratory to provide my insurance carrier any information necessary for processing my insurance claim, including but not limited to test results.

Required for insurance and patient billing - Signature of responsible party: _____ ***Date:*** _____

F. RESULT REPORTING

▪ To establish/update your provider ordering profile, please contact your account manager

STATEMENT OF MEDICAL NECESSITY - The test(s) ordered is medically necessary for the diagnosis of this patient's condition. The results from this testing will guide medical management and determine treatment decisions for this patient. As the ordering provider, I am legally authorized to request this testing. I have provided the patient with the testing information and the patient has provided informed consent to the testing I have ordered. The patient / patient's family have been counseled regarding the implications of receiving secondary findings. I explained the potential benefits and limitations of receiving secondary findings and have answered their questions. I do hereby attest that this information is true, accurate, and complete to the best of my knowledge.

_____

signature of ordering provider ***date***

(signed clinic notes will be accepted in lieu of a provider signature)

ORDERING LOCATION:

Facility:_____

Client Code:_____

Address:_____

City/State/Zip:_____

Phone:_____Fax:_____

Email:_____

ORDERING PROVIDER:

Name:_____

Delivery Method:_____

ADDITONAL REPORT(S) TO:

Name:_____ Name:_____

Delivery Method:_____ Delivery Method:_____

G. SHIPPING

Shipping supplies including collection kits, tubes, transport media, and prepaid airbills are available through our supply portal.

Local Transport: Call the laboratory (402-559-6420) to request specimen pickup or utilize your routine RPS courier.

Shipping Address: UNMC Shipping & Receiving Dock
Regional Pathology Services MSB 3500
University of Nebraska Medical Center
601 Saddle Creek Road
Omaha, NE 68108-1180

END OF FORM