Collaborative Genomics Core
UNIVERSITY OF WISCONSIN–MADISON

University of Wisconsin
Collaborative Genomics Core
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Madison, WI 53706-1578
http://www.med.wisc.edu/uwcgc

Prenatal (11/2015) **CGC# 133**

(PLEASE PRINT USING CAPITALS- FIELDS IN RED ARE REQUIRED)

(1) Patient Last Name | First Name | Middle Name

(2) Name Change- Former Last Name

(3) Patient Address

(4) City | State | Zip | County of Residence

(5) Date of Birth | (6) Age | (7) Sex ☐ Male ☐ Female

(8) Ethnicity ☐Hispanic/Latino ☐Non-Hispanic/ Latino

(9) ☐Amer Indian ☐Asian ☐Other ☐Black/African Amer ☐Pacific Islander ☐White

(10) Chart #/ Patient ID Number | (11) Submitter Specimen ID Number

(13) Additional Report Copies Needed?
Please check this box ☐ AND
Enter the clinician's name and address on the back of this form

(14) Ordering Provider

(15) NPI # _ _ _ _ _ _ _ _ _ _

(16) Attached copies of front and back of insurance card(s)?

(17) Medicare generally does not cover routine screening tests. ABN attached? ☐ YES ☐ NO

(18) ☐ MEDICAID# _____ ☐ MEDICARE# _____
☐ PRIVATE INSURANCE# _____ ☐ Bill to Submitter

(20) Please write the letter corresponding to the appropriate ICD-10 Code to the left of the test name below (where applicable)

(A) ICD-10 Code _____ (B) ICD-10 Code _____ (C) ICD-10 Code _____ (D) ICD-10 Code _____ (E) ICD-10 Code _____

(21) Date of collection | (22) Time of collection

Specimen Source ☐ Amniotic Fluid ☐ Blood ☐ Chorionic Villus Sample ☐ Paraffin Section (tissue type _____)

☐ Products of Conception (tissue type _____) ☐ Tissue Biopsy (tissue type _____)

Reason for Referral (please provide in addition to ICD-10 code above):

Clinical Information

Gestational Age: _____

Dating Method: ☐ LMP ☐ CRL ☐ Date of Implantation ☐ Other _____

Maternal Height: _____ ft, in

Maternal Weight: _____ lbs

Check all that apply:

CHROMOSOME ANALYSIS

- ☐ 801 Chromosome Analysis, Blood
- ☐ 803 Chromosome Analysis, Blood, Abridged Examination for Familial Chromosome Rearrangements
- ☐ 850 Chromosome Analysis, Amniotic Fluid
- ☐ 852 Chromosome Analysis, Amniotic Fluid, Abridged (must also order 890PREC or 890PRET)
- ☐ 855 Chromosome Analysis, Chorionic Villus Sample
- ☐ 857 Chromosome Analysis, CVS, Abridged (must also order 890PREC or 890PRET)
- ☐ 831 Chromosome Analysis, Products of Conception/ Tissue Biopsy
- ☐ 860 Tissue culture and shipment for additional testing

MOLECULAR ANALYSIS

- ☐ 828 Molecular Analysis, Fragile-X, Genetic Diagnosis
- ☐ 889 Methylation-Specific PCR, SNRPN gene, 15q11.2
- ☐ 890PREC Prenatal Microarray, Comprehensive
  - ☐ Tiered (Hold array pending chromosome analysis)
  - ☐ Concurrent (must also order 852 or 857)
- ☐ 890PRET Prenatal Microarray, Targeted
  - ☐ Tiered (Hold array pending chromosome analysis)
  - ☐ Concurrent (must also order 852 or 857)

A sample processing fee is charged for blood samples that have only FISH analysis

FISH ANALYSIS

- ☐ 873 Pre-natal Aneuploidy Panel, Amniotic Fluid
- ☐ 875 Stillbirth Aneuploidy Panel, Paraffin Embedded
- ☐ 871F25 Angelman Syndrome, Deletion 15q11.2, D15S10/ UBE3A
- ☐ 871F26 Cri du Chat (Cat Cry) Syndrome, Deletion 5p15.2, D5S721/D5S23
- ☐ 871F27 Deletion 1p36 Syndrome
- ☐ 871F28 DiGeorge /Velo-cardio-facial /Schpritzen /Conotruncal anomaly Syndrome, Deletion 22q11.2, TUPLE1
- ☐ 871F30 Prader-Willi Syndrome, Deletion 15q11.2, SNRPN
- ☐ 871F33 Wolf-Hirschhorn Syndrome, Deletion 4p16.3, WHS
- ☐ 871F34 SRY (Sex determining Region of Y), Yp11.3
- ☐ 870F52 X and Y sex chromosomes

SMART START PRENATAL SCREEN (SSPS):

Choose either Singleton or Twin:

☐ For Singleton- Pregnancy prenatal test for chromosomes 21, 18, 13 [BASIC]
- ☐ Sex chromosome aneuploidies option
- ☐ Trisomies 9 and 16 option
- ☐ Microdeletion panel [EXPANDED]

This option includes the following syndromes: 22q11 deletion (DiGeorge); 15q11 deletion (Angelman/Prader-Willi); 1p36 deletion, 4p- (Wolf-Hirschhorn); 5p- (Cri-du-Chat)

☐ For Twin- Pregnancy prenatal test for chromosomes 21, 18, 13
- ☐ Presence of Y chromosome option

This prenatal test is validated for singleton and twin pregnancies at or after 10 weeks of gestational age (8 weeks fetal age) as calculated by LMP or other appropriate method.

PATIENT CONSENT (SSPS only)

By signing this form, I, the patient having the testing performed, acknowledge that: (i) I have been offered the opportunity to ask questions and discuss with my healthcare provider the benefits, risks and limitations of the test to be performed; (ii) I have discussed with the healthcare provider ordering this test the reliability of positive or negative test results and the level of certainty that a positive test result for a given disease or condition serves as a predictor of that disease or condition; (iii) I have been informed about the availability and importance of genetic counseling and have been provided with information identifying an appropriate healthcare provider from whom I might obtain such counseling; (iv) I consent to having this test performed and I will discuss the results and appropriate medical management with my healthcare provider.

Patient signature: _____ Date: _____

MEDICAL NECESSITY STATEMENT (SSPS only)

I certify that (i) this test is medically necessary, (ii) the patient (or authorized representative on the patient's behalf) has given informed consent (which includes written informed consent or written authorization when required by law) to have this testing performed, and (iii) the informed consent obtained from the patient meets the requirements of applicable law and Patient Informed Consent. I agree to provide any and all additional information reasonable required for the testing to be performed and billed.

Healthcare provider signature: _____ Date: _____