


PRINT, SEND WITH SPECIMEN

 <p>Level 1 Trauma Center 701 Park Ave. Mpls, MN 55415</p>		<p>PLEASE REMEMBER TO:</p> <ul style="list-style-type: none"> Request/ Mark test(s) Include Billing Information Send Specimen appropriately 	<p>STAT CALL TO: FAX TO:</p>
DATE COLLECTED:	TIME:	<p>BILL TO:</p> <input type="checkbox"/> ACCOUNT <input type="checkbox"/> COMMERCIAL INSURANCE: <input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> PATIENT	
INSTITUTION:			
ADDRESS:			
REFERRING PHYSICIAN:			
Send Additional Copy to: Client or Physician name:			
ADDRESS:			
CITY:	STATE:	ZIP:	
ICD9 DIAGNOSIS CODE(S) FOR TESTS ORDERED			
<p><u>PATIENT RESPONSIBLE PARTY SIGNATURE</u> (SEE REVERSE SIDE FOR ACKNOWLEDGMENT STATEMENT:) I have read the Statement on the back of this requisition that Medicare is likely to deny payment for identified service(s) for the reason stated. If Medicare denies payment, I agree to be personally responsible for payment.</p>			
X:			

PATIENT NAME: (LAST, FIRST, MI):			
ADDRESS:		CITY:	
STATE:	ZIP CODE:	PHONE #	
DATE OF BIRTH:	SEX:	OFFICE/CHART ID#:	
PATIENT SOCIAL SECURITY #:			
HCMC MEDICAL RECORD # (IF AVAILABLE):			
Insurance	INSURANCE COMPANY NAME:		
	MEMBER INSURED ID#:	GROUP NUMBER:	
	INSURANCE ADDRESS:		
	CITY	STATE:	ZIP:
	EMPLOYER NAME:		
	MEDICARE #:		
	MEDICAID #:	STATE IF NOT MN:	
DIAGNOSIS:			

PRENATAL TESTING 612-347-3003

ALPHA-FETOPROTEIN

Maternal Serum Amniotic Fluid

DOUBLE SCREEN (AFP and BHCG)

TRIPLE SCREEN (AFP, BHCG, UE3)

FETAL LUNG MATURITY (FLM)

ACETYLCHOLINESTERASE

(Please fill out the following information when ordering the above tests)

Date of sample collection: ____/____/____

Gestation age: _____ as of ____/____/____

Determined by: _____

Race: Europe American Hispanic
 African American Native American
 Asian American Other _____

Indication:

Routine Family HX Down Syndrome
 Repeat (previous abnormal AFP) Advanced Maternal Age
 Family Hx of NTD Other: _____

CYTOGENETICS 612-347-8548

AMNIOTIC FLUID CHROMOSOME STUDY

Gestation age: _____ as of ____/____/____

BONE MARROW CHROMOSOME STUDY

HEMATOLOGIC BLOOD CHROMOSOME STUDY

WBC: _____

MALIGNANT TISSUE CHROMOSOME STUDY

Source: _____

BLOOD CHROMOSOME STUDY

Metaphase Bands
 Prometaphase Bands (High Resolution)
 Fragile X Molecular Study

PRODUCTS OF CONCEPTION/ ABORTUS/ FETAL TISSUE CHROMOSOME STUDY

SKIN BIOPSY FOR CHROMOSOME STUDY

FISH (Fluorescent in situ Hybridization)

OTHER: