SaintFrancis Hospital Center for Genetics

Shipping Address: 6161 South Yale Avenue • Tulsa, OK 74136
(918) 502-1720 Phone • (918) 502-1723 Fax • (866) 846-0315 Toll Free
www.saintfrancis.com/genetics or
www.saintfrancis.com/physicians/laboratory-testing/

Khadija Belhassan, MD,
Director of Center for Genetics
Federal Tax # 14-1841340
Medicare # 370091 CLIA #
37D0474681 CAP # 2050201

CYTOGENETICS LABORATORY TEST REQUISITION 411-002L front / 06-22

PATIENT / SPECIMEN INFORMATION

Patient Name (Last, First,MI) ☐M ☐F	SSN OR MRN	DATE OF BIRTH

RACE	DIAGNOSIS - *INDICATIONS FOR TESTING*

ICD9	SPECIMEN TYPE	COLLECTION DATE	TIME

REFERRAL SOURCE

REQUESTING / CONTACT PHYSICIAN	**REQUESTING PHYSICIAN / PRACTITIONER SIGNATURE - (REQUIRED BY MEDICARE)**

PHYSICIAN ADDRESS, CITY, STATE, ZIP CODE	PHONE NUMBER	FAX RESULTS **FAX** NUMBER ☐ No ☐ Yes _____

REFERRING FACILITY

FACILITY ADDRESS, CITY, STATE, ZIP - *IF DIFFERENT FROM ABOVE* PHONE NUMBER FAX RESULTS **FAX** NUMBER _____

☐ No ☐ Yes

ADDITIONAL REPORTS TO :

CYTOGENETIC TESTS

CHROMOSOME ANALYSIS

- ☐ Blood - Routine
- ☐ Blood - High Resolution
- ☐ Blood - for Leukemic Study
- ☐ Blood - Limited Analysis Reflexed to Array
- ☐ Blood - Mosaicism
- ☐ Bone Marrow
- ☐ Lymph Node
- ☐ Placenta
- ☐ Products of Conception - Fetal Demise

CELL CULTURE ONLY

- ☐ Blood
- ☐ Bone Marrow
- ☐ Products of Conception
- ☐ Skin or Solid Tissue

MICROARRAY ANALYSIS

- ☐ Chromosome Array (aCGH)
- ☐ Parental Studies (aCGH)*
  - (include child's array report)

FISH TESTS

- ☐ Aneuploidy (Newborn 13, 18, 21, X & Y)*

*Notify Lab Upon Collection

Hematologic Malignancies

Panels

- ☐ ALL profile
- ☐ AML/MDS profile
- ☐ CLL profile
- ☐ Multiple myeloma profile

Single

- ☐ AML1 / ETO 8;21 translocation
- ☐ BCR / ABL 9;22 translocation
- ☐ CBFB Inversion 16
- ☐ IGH / BCL2 14;18 translocation
- ☐ CCND1 / IGH 11;14 translocation
- ☐ IGH rearrangements 14q32
- ☐ MLL rearrangements 11q23
- ☐ PML / RARA 15;17 translocation
- ☐ TEL / AML1 12;21 translocation

Solid Tumor Malignancies

- ☐ ALK Rearrangement - Lung
- ☐ MYC Rearrangement – Lymph Node
- ☐ HER-2 / neu (Breast & Gastric Cancer)
- ☐ ROS1 Rearrangement - Lung

Microdeletion Syndromes

- ☐ Deletion 22q / DiGeorge / VCF Syndrome

Sex Chromosomes

- ☐ SRY gene / X chromosome
- ☐ X and Y chromosomes

OTHER (specify)

FOR GENETICS AT SAINT FRANCIS USE ONLY

DATE RECEIVED	TIME	TYPE / AMOUNT RECEIVED	ACCESSION NUMBER

CASE NUMBER	PATIENT NUMBER	INVOICE NUMBER	AUTHORIZATION NUMBER

SaintFrancis Center for Genetics Hospital
Shipping Address: 6161 South Yale Avenue • Tulsa, OK 74136
(918) 502-1720 Phone • (918) 502-1723 Fax • (866) 846-0315 Toll Free
www.saintfrancis.com/genetics or www.saintfrancis.com/physicians/laboratory-testing/

BILLING INFORMATION 411-002L back 06-22

PAYMENT INFORMATION - *INDICATE ONE*

SELF PAY (Payment in Full from Patient or Guarantor)

Check or Money Order Payable to Saint Francis Hospital

Credit Card VISA MC	CARDHOLDER NAME - *PRINT*	ZIP CODE

ACCOUNT NUMBER	EXPIRATION DATE	SECURITY NO.	CARDHOLDER - *SIGNATURE*

Payment for Medical Care: It is understood and agreed that the undersigned or a designated agent will be responsible and assume an obligation to pay the Center for Genetics at Saint Francis all costs for genetic evaluation and testing rendered to the person whose name appears within thirty (30) days after having been notified of the amount due and owing or will work out a satisfactory payment plan with the Center for Genetics at Saint Francis. It is further understood and agreed that the undersigned or designated agent will, at all times, remain responsible for the costs of said genetic evaluation and testing.

PATIENT SIGNATURE - *MUST BE 18 YEARS OR OLDER TO SIGN* DATE

PARENT / LEGAL GUARDIAN - *REQUIRED IF PATIENT IS LESS THAT 18 YEARS OF AGE OR IS NOT LEGALLY COMPETENT*

ADDRESS, CITY, STATE, ZIP	HOME PHONE NUMBER ( )
EMPLOYER	WORK PHONE NUMBER ( )

WITNESS - *SIGNATURE* DATE

INSURANCE (Filed as Courtesy - Patient Ultimately Responsible for Balance of Account)

SUBMIT ALL OF THE INFORMATION BELOW WITH FRONT AND BACK COPY OF CARD AND REQUIRED AUTHORIZATION. INCOMPLETE SUBMISSIONS COULD DELAY TESTING. FOR OUT OF STATE PATIENTS, THE ONLY BILLABLE PLANS ARE AETNA, Blue Cross Blue Shield, United Healthcare and CIGNA.

POLICY HOLDER NAME	POLICY HOLDER SOCIAL SECURITY NUMBER	POLICY HOLDER DATE OF BIRTH

ADDRESS, CITY, STATE, ZIP	HOME PHONE NUMBER ( )
EMPLOYER	WORK PHONE NUMBER ( )

PRIMARY CARE PHYSICIAN	PHYSICIAN NPI NUMBER

INSURANCE COMPANY NAME	INSURANCE COMPANY PHONE	POLICY NUMBER	GROUP NUMBER

INSURANCE COMPANY ADDRESS, CITY, STATE, ZIP CODE

REFERRAL NUMBER	REFERRAL DATE	EFFECTIVE DATE	AUTHORIZATION NUMBER

MEDICARE NUMBER	MEDICAID NUMBER (OKLAHOMA ONLY)

Authorization to Release Protected Health Information, Assign Benefits, and Accept Responsibility for My Account: I authorize any physician or laboratory who has treated me or my dependent(s) to furnish any medical information requested. In consideration of services rendered, I transfer and assign any benefits of insurance to Center for Genetics at Saint Francis. I understand that I am responsible for any co-pay or deductible amounts if the Center for Genetics at Saint Francis is a participant in my health plan. I understand I am fully responsible for payment of my account if the Center for Genetics at Saint Francis is not a participant with my health plan, and my health plan does not reimburse (or only partially reimburses) my medical services due to lack of authorization or medical necessity. **The information permitted for release may include records which indicate the presence of a communicable or venereal disease including but not limited to Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS), and/or mental health information.**

PATIENT / GUARANTOR - ***SIGNATURE*** DATE

REFERRING FACILITY

FACILITY NAME	PHONE NUMBER	FAX NUMBER

BILLING ADDRESS