Icahn School of Medicine at Mount Sinai
One Gustave L. Levy Place, Box 1497
New York, NY 10029-6574
Phone: 212-241-7518 / Fax: 212-241-0139
Tax ID# 13-6171197
CLIA# 33D0653419

PRENATAL TESTING AND GENETIC SCREENING REQUISITION

Mount Sinai Genetic Testing Laboratory
Mount Sinai Medical Center

ACCESSION NO.

DATE / /

LabForms 888-200-5114

PATIENT INFORMATION

LAST NAME | FIRST NAME

DATE OF BIRTH / / | SEX M ☐ F ☐

PARTNER / SPOUSE LAST NAME | PARTNER / SPOUSE FIRST NAME

TELEPHONE (HOME) | TELEPHONE (CELL) | TELEPHONE (WORK)

ADDRESS

CITY / STATE / ZIP

BILLING INFORMATION

POLICYHOLDER LAST NAME | POLICYHOLDER FIRST NAME | POLICYHOLDER DOB / /

INSURANCE CARRIER | INSURANCE ID | GROUP NO.

BILLING ADDRESS

OTHER HEALTH COVERAGE (IDENTIFY)

ASSIGNMENT AND RELEASE:
I hereby authorize my insurance benefits be paid directly to the provider and I understand that I am financially responsible for uncovered services. I also authorize the release of any information required to process the claim.

SIGNATURE DATE / /

REFERRING PHYSICIAN INFORMATION

PHYSICIAN SIGNATURE OF CONSENT REQUIRED BELOW: I certify that the patient specified above and/or their legal guardian has been informed of the benefits, risks, and limitations of the laboratory test(s) requested. I have answered this person's questions. I have obtained informed consent from the patient or their legal guardian for this testing.

SIGNATURE DATE (MM/DD/YY) / /

INDICATIONS FOR TESTING

☐ GENERAL CARRIER SCREENING (NO FAMILY HISTORY)
☐ FAMILY HISTORY OF _____ ☐ PARTNER CARRIER OF:_____
☐ ADVANCED MATERNAL AGE ☐ ULTRASOUND FINDING_____
☐ POSITIVE PRENATAL ANEUPLOIDY SCREEN _____
☐ OTHER _____

ICD9 Dx CODE(S) (Required if indication is not specified above)

COLLECTION DATE: _____ / _____ / _____

OF BLOOD TUBES SENT: YELLOW_____ PURPLE_____ RED_____ GREEN_____

LABORATORY TEST(S) ORDERED

Cytogenetics and Cytogenomics

Chromosome Analysis

☐ Amniotic Fluid + AFP **G.A.**_____
☐ By LMP ☐ By Ultrasound **Date**_____
☐ CVS
☐ Peripheral Blood
☐ Peripheral Blood Mosaicism Study (50 Cells)
☐ Peripheral Blood STAT (newborn blood includes Aneuploidy FISH)
☐ Fetal Blood (PUBS)
☐ Skin Biopsy
☐ Products of Conception (In case of growth failure, reflex to P.O.C. FISH Panel is included)

Additional Cell Culture

☐ Hold ☐ Grow_____

☐ Aneuploidy FISH (prenatal specimens)
☐ Single Microdeletion FISH
Please specify disease: _____
☐ Microdeletion FISH Panel
☐ Subtelomere FISH - single probe only
☐ 180K Array CGH + SNPs (pre-/postnatal)
☐ FISH STAT
Please specify disease:_____

Molecular

☐ FGFR3 Hotspot Panel
☐ reflex to sequencing if negative
☐ Limb Defects Next Gen Sequencing Panel (7 genes)
☐ Noonan Syndrome Next Gen Sequencing Panel (14 genes)
☐ Maternal Cell Contamination
☐ Other: _____

☐ MaterniT21 PLUS*
MaterniT21 PLUS is a trademark of Sequenom

Specimen Required:
Two 10 ML Whole Blood BCT Streck Tubes (Black/Tan Top)
***Please Call 212-241-7518 for Supplies and Specimen Pickup**

SCMM ID #: _____
☐ Opt-out for subchromosomal copy variants (microdeletions), chromosomes 22 and 16

Ordering Physician_____ Fax #: _____
Referring Physician _____ Fax #: _____

Gestational Age:_____ **Method For Determining Gestational Age**:
☐ LMP ☐ Ultrasound

Patient Height: _____ **Weight:** _____

Increased Risk due to (please check one)	If Multifetal Gestation (please check one)	ICD9 Dx CODE(S) (Required)
☐ Advanced Maternal Age	☐ Twins	☐ 659.63 ☐ 796.5
☐ Serum Biochemical Screening	☐ Triplets	☐ 659.53 ☐ Other:
☐ Ultrasound Finding		☐ 655.13 _____
☐ Personal or Family History		

Limitations of the MaterniT21 PLUS Test
DNA test results do not provide a definitive genetic risk in all individuals. Cell-free fetal DNA does not replace the accuracy and precision of prenatal diagnosis with CVS or amniocentesis. A patient with a positive test result should be referred for genetic counseling and offered invasive prenatal diagnosis for confirmation of test results. A negative test result does not ensure an unaffected pregnancy. While results of this testing are highly accurate, not all chromosomal abnormalities may be detected due to placental, maternal or fetal mosaicism, or other causes. Sex chromosomal aneuploidies will not be reported for multiple gestations.

Molecular - Carrier Screening Panels

☐ Basic Pan-Ethnic (CF, Fragile X, SMA and SLOS)
☐ Expanded Ashkenazi Jewish (38 diseases individually listed below)
☐ NEW Ashkenazi Jewish (18 diseases)[E]
☐ Mt Sinai – Counsyl Expanded Pan-Ethnic (73 additional diseases only, listed on back)
☐ All-inclusive Pan-Ethnic (includes all 111 disorders above)

Molecular - Individual Tests

☐ Abetalipoproteinemia[E]
☐ Alport Syndrome, AR[E]
☐ Arthrogryposis, Mental Retardation & Seizures[E]
☐ Bardet-Biedl (BBS2)[E]
☐ Bloom Syndrome
☐ Canavan Disease
☐ Carnitine Palmitoyltransferase II Deficiency[E]
☐ Congenital Amegakaryocytic Thrombocytopenia[E]
☐ Congenital Disorder of Glycosylation Ia[E]
☐ Cystic Fibrosis (CF)
☐ Dyskeratosis Congenita, AR[E]
☐ Ehlers-Danlos VIIC[E]
☐ Familial Dysautonomia
☐ Familial Hyperinsulinism (*ABCC8*)
☐ Fanconi Anemia C
☐ Fragile X Syndrome (females only)
☐ Galactosemia[E]
☐ Gaucher Disease
☐ Glycogen Storage Disease Ia
☐ Joubert syndrome 2
☐ Lipoamide Dehydrogenase Deficiency (E3)
☐ Maple Syrup Urine Disease Ib
☐ Mucolipidosis IV
☐ Multiple Sulphatase Deficiency[E]
☐ Nemaline Myopathy (*NEB*)
☐ Niemann-Pick Disease A and B
☐ 3-Phosphoglycerate Dehydrogenase Deficiency[E]
☐ Polycystic Kidney Disease, AR[E]
☐ Retinitis Pigmentosa 59[E]
☐ Smith-Lemli-Opitz (SLOS)[E]
☐ Spinal Muscular Atrophy (SMA) (includes Enhanced SMA Testing)*
☐ Tay-Sachs Disease
☐ Tyrosinemia I[E]
☐ Usher IF
☐ Usher III
☐ Walker-Warburg (*FKTN*)
☐ Wilson Disease[E]
☐ Zellweger Syndrome (*PEX2*)[E]
☐ Other: _____

*Enhanced SMA testing includes analysis for presence/absence of g.27134T>G to identify (2+0) silent carriers.

LABORATORY TESTING INFORMATION

Are you of 100% Ashkenazi Jewish descent? ☐ YES ☐ NO
If not, ethnic background: _____

Are you or your partner pregnant? ☐ YES ☐ NO
Currently using birth control medication? ☐ YES ☐ NO

Previous Carrier Screening? ☐ YES ☐ NO
Specify:_____

LAB USE ONLY

We accept VISA, MasterCard, AMEX and personal checks.
Make checks payable to: Mt. Sinai Genetic Testing Lab

For billing questions, call: 212-241-8717

TOTAL CHARGES:
AMOUNT PAID:
BALANCE DUE: