NATIONWIDE CHILDREN'S

Laboratory Services
700 Children's Drive, Columbus, Ohio 43205
P: (614) 722-5477 / (800) 934-6575
F: (614) 722-5478 / (877) 722-5478
NationwideChildrens.org/Lab

Ship samples to the CPA Lab, Room C1955

Practice/ Office Name: _____
Address: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____

Please Mark Billing Option: Patient Bill: ____ / Client Bill _____

Patient Information	
Legal Last Name:	
First Name:	MI:
MRN/ Patient ID:	
DOB:	
Address:	
City, State, Zip:	
Phone #: ( )	
Race:	
Ethnicity:	
Sex: [ ] Male [ ] Female	
Specimen Information	
Collection Date:	Time: [ ] AM [ ] PM
Collected By (full name):	
Storage Temp: [ ] Refrigerated [ ] Frozen [ ] Room Temperature	

Parent/Guardian / Billing Information	
Guardian Legal Last Name:	
Guardian First Name:	MI:
Patient Relationship:	
Guardian Contact Phone #: ( )	
Subscriber Legal Last Name:	
Subscriber First Name and MI:	
Subscriber DOB:	Sex: [ ] Male [ ] Female
Subscriber Social Security #:	
Subscriber Phone #: ( )	
Subscriber Address (if different from patient):	
Insurance Co. Name:	
Policy #:	Group #:
Insurance Address:	
Secondary Insurance Co. Name:	

PRENATAL TEST REQUISITION FORM

Gestation:____weeks____days ; Grav:____ Para:___ SAb:___ TAb:___
Fetal Sex: [ ] Male [ ] Female [ ] Unknown
Egg Donor Used for This Pregnancy? [ ] No [ ] Yes
Specimen: [ ] Amniotic Fluid (AF): Volume _____mL; Color_____
[ ] Fetal Fluid: Source _____ , Volume ____mL
[ ] PUBS Fetal Blood: Volume ____mL (≥1 mL NaHep)

CYTOGENETIC TESTING, PRENATAL SPECIMEN
[ ] Chromosome Analysis, Full Study (15 Colonies) (≥20mL AF requested)
[ ] 5-cell Abbreviated Chromosome Analysis (≥5mL AF requested)
[ ] Aneuploidy FISH Screen for 13,18,21,X,Y (addt'l 5mL AF requested)

MICROARRAY ANALYSIS, PRENATAL SPECIMEN
***Maternal blood is REQUIRED for all Prenatal Microarray Tests**
***If <20mL AF submitted, Microarray will be done on cultured AF cells**
A. [ ] Prenatal Microarray **with Parental Testing**-[ ] Run if full karyotype normal
[ ] Maternal blood enclosed (4mL EDTA) - REQUIRED
[ ] Paternal blood enclosed (4mL EDTA) - Complete a separate requisition form for the Father of Pregnancy -
Father's Name & DOB_____
B. [ ] Prenatal Microarray (**No Parental Testing**)-[ ] Run if full karyotype normal
[ ] Maternal blood enclosed (4mL EDTA) - REQUIRED

OTHER AMNIOTIC FLUID (AF) / PRENATAL SPECIMEN TESTING:
[ ] AF-AFP, Reflex to AChE & Fetal Hb (test code XAFRA)
[ ] Infectious Disease Qualitative PCR, Choose Below:
[ ] CMV (test code CMVTT) [ ] Parvo B19 (test code B19PCR)
[ ] Toxoplasma (test code XTOXG) [ ] HSV (test code HSVTT)
[ ] SLO/7-DHC Biochem Study (test code 7DHCA)
[ ] Other FISH Study: ___22q11, ___STS, Other_____
[ ] DNA Isolation & Cryopreservation of Cultured Amniocytes
[ ] Cryopreservation of Cultured Amniocytes (No DNA Isolation)
[ ] Culture Cells for Additional Test (addt'l 10 mL AF requested), Specify
Test/Lab _____
_____
***For fetal DNA testing, send 4mL EDTA maternal blood with AF**

MATERNAL / PATERNAL TESTING: ___mL NaHep; ___mL EDTA
[ ] BLOOD Chromosome Analysis (4mL NaHep)
[ ] BLOOD Microarray Analysis (4mL EDTA)
[ ] Maternal Cell Contamination (MCC) Studies (4mL EDTA)
Proband Name:_____ DOB:_____
[ ] Other: _____
[ ] Fragile X (4mL EDTA): ____Carrier Test OR ____Diagnostic Test
[ ] Spinal Muscular Atrophy (SMA) Dosage Analysis (4 mL EDTA)
For ____ Carrier Screening OR ____ Diagnostic Testing
[ ] Cystic Fibrosis Common Mutation Panel (4mL EDTA)
For ____ Carrier Screening OR ____ Diagnostic Testing
Family History of CF? ___No ___Yes, Relative_____
_____(eg. sister) is ___Carrier ___Affected

INDICATIONS FOR STUDY ** REQUIRED **
Please provide indication for testing and relevant clinical and family history to allow accurate interpretation of test results.
[ ] Advanced Maternal Age
[ ] Abnormal ___First Trimester Screen ___Quad Screen
___Cell-free Fetal DNA Screen (NIPS/NIPT)
Down synd risk:_____ Other: _____
[ ] 2 or More Spontaneous Abortions
[ ] Family History (describe below)
[ ] Ultrasound Abnormality (describe below)
[ ] Other (describe below)
Clinical Findings:_____
_____
_____

Genetic Counselor Name: _____
Cytogenetics Lab: TEL 614-722-5321 FAX 614-722-5471
After Hours: TEL 614-722-5351 for specimen pickup
TEL (614) 722-5477 for questions

Diagnosis/ ICD-10 _____ Physician (Print name) _____ Physician's Signature (Required) _____

Date _____ Time _____