Requisition Form – Pediatric Analysis

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Client Information

Referring Physician _____ NPI _____

Ordering Physician _____ NPI _____

Genetic Counselor/Clinical Contact _____

Tel _____ Fax _____

Email _____

Authorized Signature _____

Patient Information

Last Name _____ First Name _____

DOB _____ Gender _____

Street Address _____

City, State, Zip _____

Tel _____

Email _____

Medical Record Number _____

Billing Information

Bill: ❑ Institution ❑ Insurance ❑ Medicare ❑ Medicaid ❑ Patient

Insurance Information ❑ See attached

Insured Information Name _____

Relationship to Patient ❑ Self ❑ Spouse ❑ Child ❑ Other: _____

Primary Insurance Co. _____ Authorization # _____

Billing Address _____ Insured # _____

Billing City, State, Zip _____ Group # _____

Secondary Insurance Co. _____ Authorization # _____

Billing Address _____ Insured # _____

Billing City, State, Zip _____ Group # _____

For Patient Bill cases, complete and submit "Self-Pay Testing Option" form. Testing will not be performed unless a completed form is received.

Patient Authorization/Assignment

I authorize CombiMatrix to obtain and release relevant medical and other information as needed to submit claims to Medicaid, Medicare, or Medicare Supplemental for laboratory services CombiMatrix provides to me. I assign insurance benefits to CombiMatrix and acknowledge that charges not covered by my insurance, including any applicable copayments or deductibles, are my responsibility, and I agree to pay them.

_____

Print Name of Patient or Guardian

_____

Signature of Patient or Guardian Date (mm/dd/yyyy)

Clinical / Specimen Information

Collection Date _____ # Tubes _____

Specimen ID #(s) _____

Sample Type

❑ Whole blood - EDTA (purple top)
❑ Whole blood - NaHep (green top)
❑ Extracted DNA _____
❑ Tissue/cultured fibroblasts
❑ Buccal swab (microarray only)
❑ Other _____

Indications for Testing

Please provide as much detail as possible about the patient's phenotype. Not only is this information utilized in the result interpretation process, it also assists with further classification of copy number variations that are currently thought to represent variants of uncertain clinical significance (VOUS). Please indicate the patient's developmental status below, and then specify the phenotypic features on the Pediatric Phenotypic Checklist.

Developmental Status

❑ Autistic disorder (F84.0)
❑ Development disorder of speech & language, unspecified (F80.9)
❑ Specific developmental disorder of motor function (F82)
❑ Delayed milestone in childhood (R62.0)
❑ Developmental disorder of scholastic skills, unspecified (F81.9)
❑ Intellectual disability ❑ Mild (F70) ❑ Moderate (F71) ❑ Severe (F72)

❑ Other _____ ❑ ICD-10 _____

Clinical Phenotype

Please indicate abnormalities on the Pediatric Phenotypic Checklist provided with the CombiMatrix kits.

Test Selections

Developmental Disorders

❑ Chromosomal microarray analysis (with confirmation FISH when indicated)
Please note that follow-up testing may require a pheripheral blood sample.

❑ Karyotype on peripheral blood sample (cannot be performed on buccal swab)

❑ Fragile X

Parental/ Familial Studies

For parental or family studies, please complete the Parental and Family Studies Test Requisition form. You can access this and other forms on our website at: www.combimatrix.com/providers/forms.

Special Instructions/Additional Testing Requests

CombiMatrix | 310 Goddard, Suite 150, Irvine, CA 92618 | T: 800.710.0624 | F: 949.753.4725 | www.combimatrix.com

Phenotypic Checklist – Pediatric

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The accurate interpretation and reporting of genetic results relies on the provision of pertinent clinical and family history information. To help ensure the most clinically appropriate interpretation of results, please complete this clinical information form. Testing cannot be initiated without a reason for referral.

Please Check All That Apply

Perinatal History
- ❑ Prematurity
- ❑ IUGR
- ❑ Oligohydramnios
- ❑ Polyhydramnios
- ❑ Other fetal anomaly: _____
- ❑ None specified

Developmental/Behavioral
- ❑ Fine motor delay
- ❑ Gross motor delay
- ❑ Speech delay
- ❑ Learning disability
- ❑ Intellectual disability
- ❑ Autistic features
- ❑ Autism spectrum disorder
- ❑ Oppositional-defiant disorder
- ❑ Psychiatric illness:
  - ❑ Bipolar disorder
  - ❑ Anxiety
  - ❑ Depression
  - ❑ ADHD
  - ❑ Other: _____

Craniofacial
- ❑ Cleft lip
- ❑ Cleft palate
- ❑ Coloboma
- ❑ Craniosynostosis
- ❑ Dysmorphic facial features
- ❑ Macrocephaly
- ❑ Microcephaly
- ❑ Hearing loss
- ❑ Ear malformation
- ❑ Cataracts

Cardiac
- ❑ Atrial septal defect
- ❑ AVSD/AV canal defect
- ❑ Coarctation of the aorta
- ❑ Hypoplastic left heart
- ❑ Tetralogy of Fallot
- ❑ Ventricular septal defect
- ❑ Dilated aortic root
- ❑ Cardiomyopathy: _____
- ❑ Arrhythmia

Cutaneous
- ❑ Hyperpigmentation
- ❑ Hypopigmentation
- ❑ Cafe au lait spots
- ❑ Eczema

Gastrointestinal
- ❑ Gastroschisis
- ❑ Hirschprung disease
- ❑ Omphalocele
- ❑ Pyloric stenosis
- ❑ Trachealesophageal fistula
- ❑ Meconium ileus
- ❑ Anal atresia
- ❑ Diaphragmatic hernia

Genitourinary
- ❑ Ambiguous genitalia
- ❑ Hydronephrosis
- ❑ Kidney anomaly: _____
- ❑ Hypospadias

Growth
- ❑ Short stature
- ❑ Tall stature
- ❑ Obesity
- ❑ Failure to thrive
- ❑ Delayed puberty
- ❑ Precocious puberty

Musculoskeletal
- ❑ Contractures (arthrogryposis)
- ❑ Club foot
- ❑ Diaphragmatic hernia
- ❑ Limb anomaly
- ❑ Polydactyly (hands)
- ❑ Polydactyly (feet)
- ❑ Syndactyly (hands)
- ❑ Syndactyly (feet)
- ❑ Vertebral anomaly

Neurological
- ❑ Ataxia
- ❑ Cerebral palsy
- ❑ Dystonia
- ❑ Hypotonia
- ❑ Hypertonia
- ❑ Developmental regression
- ❑ Muscle weakness
- ❑ Neural tube defect
- ❑ Seizures
- ❑ Abnormal brain MRI: _____

Family History
- ❑ Parents with ≥ 2 miscarriages
- ❑ Relative with known chromosome abnormality:

_____

- ❑ Other relatives with clinical history similar to patient (please describe)

_____

_____

_____

Other (not on list)

_____

_____

_____

As a participant in the International Collaboration for Clinical Genomics (ICCG), this clinical cytogenetics laboratory contributes submitted clinical information and test results to a HIPAA compliant, de-identified public database as part of the NIH's effort to improve understanding of the relationship between genetic changes and clinical symptoms. Confidentiality is maintained.

Patients may request to opt out of this scientific effort by 1) checking the box below or 2) calling the laboratory at 800.710.0624 and asking to speak with a laboratory genetic counselor. Please call with any questions.

❑ Mark here to indicate refusal for inclusion in these efforts by checking this box. If the box is not marked, data will be anonymized and submitted.

Testing Notes

CombiMatrix will attempt to perform all tests ordered. If the sample size is insufficient to do so, CombiMatrix will perform testing according to a predefined standing order contingency plan. If no standing order contingency plan exists, CombiMatrix will promptly notify the client and discuss what testing can and cannot be performed. If CombiMatrix is unable to make contact with a client the same day (the day the sample was received) to determine what testing is desired, CombiMatrix will run only the tests that are possible based on the sample received. To set up a standing order contingency plan, please call our Genetic Counseling Services at 949.255.0921.

If testing other than the options listed on this form is desired, please contact one of CombiMatrix's genetic counselors to discuss whether it is possible to accommodate your request prior to sending the sample. If prior arrangements are not made, CombiMatrix cannot guarantee the ability to provide the requested testing.

Patient Information

Please place the completed label from the Test Requisition Form with the patient information here and return this form with the test sample:

MM DD YY
Specimen Collection Date

Patient DOB

Last Name

First Name

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