# Specimens:	Blue:	Lav:	Red:	SST:	Grn:	Gray:	Urine	Micro:
Collect Date:	Time:	By:	Depot:	ABN Signed: ☐				
MR #:	A #:							

STAT

REQUIRED (PRINT OR PATIENT LABEL)

Name(Last, First, MI)

Date of Birth | Sex:(circle) M F

Street Address

Street Address 2

City, State, Zip

Phone Number | Chart Number

Indicate primary (1) and secondary (2) insurance

__Blue Cross/Shield __Child Health Plus __MVP

__Blue Choice __Medicaid __MVPG

_Medicare Blue Choice __Medicare __Aetna

__Other ____________________

1. Primary Contract #:

Subscriber's Name:

Relationship to Subscriber:

2. Secondary Contract

Subscriber's Name:

Relationship to Subscriber:

Doctor: ____________________

Address: ____________________

Phone Results to: Fax Results to:

Ordering Provider's Signature

Date of Signature

Diagnosis Mandatory: Signs/Symptoms or ICD10 Codes

If ordered for screening, list test name here and write "SCREENING" after it

Send Additional Reports To: (Full Name/Address)

Compliance is Mandatory and Regulated. For the laboratory to bill properly and receive payment for tests ordered on Medicare Beneficiaries, specific ICD-10 code(s) or a descriptive diagnosis must be included on each patient for each test ordered.It is critical that the diagnosis provided to the lab is consistent with those recorded in the patient medical record on the date of service.

Patient History Mandatory

Chief Complaint/Diagnosis:

ClinicalHistory/Relevant Family History:

Current Medications: (list all drugs taken in last 4 days)

Current Diet/Supplementation Time of last meal:

BIOCHEMICAL GENETICS (275-8483)

Code		Test	Specimen
33526	☐	Amino Acid Analysis, Quantitative	Green On Ice
27152	☐	Glycine Profile for NKH *(Amino Acid Analysis, Quant. & Glycine, CSF)*	Green On Ice CSF On Ice
48033	☐	MSUD Profile, Quant. *(Valine, Allo-Isoleucine, Isoleucine, and Leucine)*	Green On Ice
45828	☐	PKU Profile	Whole Blood Filter Card
45830	☐	PKU Profile, Plasma	Green on Ice NA Heparin
44418	☐	Ammonia	Lavender On Ice
	☐	Other: ____________	
15835	☐	Amino Acids, Urine, Quantitative (includes Creatinine) MINIMUM: 2.0 ml, PREFERRED: 5 ml	Urine On Ice
17326	☐	Organic Acid, Urine, Qualitative by GC/MS (includes Creatinine) MINIMUM: 4.0 ml, PREFERRED: 10 ml	Urine On Ice

REFERENCE LAB TESTS (758-0520)

(01) NYS APPROVAL REQUIRED PRIOR TO SPECIMEN COLLECTION
(02) SPECIAL FORM FROM PERFORMING LAB REQUIRED
(03) SAMPLES MUST BE DRAWN MON-WED/MUST BE SHIPPED SAME DAY AS COLLECTED

REFERENCE TESTING REQUIRES SUBSPECIALTY- PHYSICIAN'S SIGNATURE

	Code		Test	Specimen
BLOOD	29008	☐	*Acylcarnitine*	Green On Ice
	32221	☐	*Carbohydrate Deficient Transferrin (CDG)*	Red On Ice
	40000	☐	*Carboxylase (02, 03), Control req'd*	Yellow ACD-A
	30308	☐	*Carnitine Free & Total*	Green On Ice
	17756	☐	*Galactose 1 PO4 (02, 03)*	Green
	19979	☐	*Gal 1 Uridyl Transferace*	Lav On Ice
	46376	☐	*Guanidinoacetate (GAMT)*	Green On Ice
	44462	☐	*Lysosomal Enzyme (02, 03)*	Green Rm Temp
	20538	☐	*Methylmalonic Acid, Serum*	SST On Ice
	17502	☐	*PKU CoFactor*	Filter Paper
	20137	☐	*Fatty Acid Profile, Peroxisomal (C22-C26)*	SST On Ice
	23962	☐	*Fatty Acid Profile, Essential (C12-C24)*	SST On Ice
URINE	34008	☐	*Acylglycine*	Urine On Ice
	19762	☐	*Galactitol*	Urine On Ice
	13304	☐	*Methylmalonic Acid, Urine*	Urine On Ice
	23049	☐	*Mucopolysaccharides (01)*	Urine On Ice
	42704	☐	*Sulfocysteine*	Urine On Ice
	26725	☐	*Sialic Acid*	Urine On Ice

PATIENT CONSENT

I have read the information on the consent form and discussed it with my health care provider. I have been given the opportunity to ask questions and have them answered about the test ordered. I authorize collection and analysis of the necessary sample(s).

Patient/Legal Guardian: *Date:*

HEALTHCARE PROVIDER CONSENT

I attest that I have reviewed the requirements for genetic testing ordered on the requisition with the patient. I have conveyed the required information to the patient and obtained consent.

Health Care Provider: *Date:*

Important Information about Genetic Testing

1. One or more of the following tests is/are being ordered to look for changes gene products which are known to be associated with the specific condition in question.

   Plasma/Urine Amino Acid Testing: This test measures amino acids in blood or urine to look for abnormalities that may suggest a genetic defect in the body's processing of one or more of these amino acids. This test may be used as a follow-up to NYS Newborn screening, to monitor treatment in a patient with a genetic defect involving amino acids, or to rule out such a disease in an at risk patient.

   Phenylketonuria (PKU) Testing: Measures blood levels of two amino acids, phenylalanine and tyrosine. These results will allow your healthcare team to monitor and adjust your diet to minimize your risks of complications from your phenylketonuria.

   Maple Syrup Urine Disease (MSUD) Testing: Measures blood levels of leucine, isoleucine and valine to test for a genetic disease called maple syrup urine disease. This test may also be used to monitor dietary treatment in known MSUD patients.

   Urine Organic Acid Testing: This test looks for the presence of chemical compounds in the urine that will suggest abnormal processes in the body. Some patterns may suggest a genetic cause while others may indicate other disease processes.

2. Genetic counseling is available prior to signing consent. This test may reveal that the individual tested is affected with the condition, carries the genetic pre-disposition for it, or that he/she does not. If a positive result is obtained, a medical and/or genetic counseling follow-up may be advised and is available.

3. Genetic Testing is ordinarily highly accurate, however, in some cases results may not be obtained or may be inconclusive. Also, accurate genetic testing depends upon an accurate diagnosis in affected family members. If the diagnosis in a family is not certain, results can be misleading. I have been able to discuss the expected accuracy of the testing in my particular case. Initial_______

4. Some genetic testing may require comparison of samples from multiple family members with their consent, and in these cases, previous unknown non-paternity can be discovered.

5. Some genetic tests are only done by a few laboratories in the world. This sample may need to be sent out of state to laboratories that are not certified by the New York State Health Department. In these cases, approval for testing will be obtained from New York State.

6. Records of this testing or test results will not be released to anyone other than entities that can receive them by law, myself, my referring doctors, and Strong Memorial Hospital Medical records unless I specify otherwise. Initials_______

7. No tests other than those authorized shall be performed on the biological sample and that the sample shall be destroyed at the end of the testing process or not more than sixty days after the sample was taken. Any part of the biological sample not used for specific testing may be retained for five years and used for medical research as long as names and other identifying information are not released. Initial_______

8. I indicate my desire to opt out of participation in anonymized research studies using my DNA sample. Initial________