UR MEDICINE | Labs

#Specimens:	Blue:	Lav:	Red:	SST:	Gm:	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:

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 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 of service.

CONSTITUTIONAL STUDIES *INFORMED CONSENT REQUIRED*

SPECIMEN TYPE

- ☐ Amniotic Fluid ☐ CVS Gestational Age: _____ — Sterile container, transport room temp, transport media upon request.
- ☐ Peripheral Blood — Green top sodium heparin, transport room temp.
- ☐ Tissue (specify): _____ — Sterile container, media/sterile saline, transport room temp, transport media upon request.
- ☐ POC (Do not add Formalin) — Sterile container, media/sterile saline, transport room temp, transport media upon request.
- ☐ Other (specify): _____

TEST(S) *Patient Consent Required

- ☐ Chromosome Analysis
- ☐ FISH (AneuVysion) (13, 18, 21, X, Y)
- ☐ Fish Other (specify): _____
- ☐ MicroArray ☐ Parental FISHP: _____
- ☐ REFLEX to MicroArray
- ☐ Direct Array
- ☐ Culture Only
- ☐ Send Out (specify): _____

INDICATION(S) FOR TEST

- ☐ Abnormal Ultrasound
- ☐ Advanced Maternal Age
- ☐ Abnormal Screen (specify): _____
- ☐ History of SAB
- ☐ Family History Chromosome Abnormality (specify): _____
- ☐ Other (specify): _____

PATIENT CONSENT

I have read the information on the back of this form and discussed it with my health care provider. I have been given the opportunity to ask questions and have them answered from the tests 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 order on the requisition with the patient. I have conveyed the required information to the patient and obtained consent.

Health Care Provider: _____ Date: _____

HEMATOLOGY/ONCOLOGY CYTOGENTICS ANALYSIS

SPECIMEN TYPE

- ☐ Bone Marrow — Green top sodium heparin, transport at room temp.
- ☐ Peripheral Blood — Green top sodium heparin, transport at room temp.
- ☐ Bladder Wash — Sterile Container/Ship on Ice, Cold Packs/Refrig.
- ☐ Urine — Sterile Container/Ship on Ice, Cold Packs/Refrig.
- ☐ Flow: _____
- ☐ FFPE: Block _____
- ☐ Tissue (specify): _____
- ☐ Other (specify): _____

INDICATION(S) FOR TEST

- ☐ Diagnosis (specify): _____
- ☐ Post ALLO BMT ☐ Male Donor ☐ Female Donor
- ☐ Hematuria
- ☐ History Bladder Cancer
- ☐ Other: _____

INDICATION(S) FOR TEST

- ☐ Chromosome Analysis
- ☐ FISH (specify probes): _____
- ☐ FISH (UroVysion)
- ☐ Send Out (specify): _____

CYTOGENETICS V. 8/13/24

CYTOGENETICS LABORATORY 275-5859

UR Medicine Labs Cytogenetics Laboratory

601 Elmwood Ave
Rochester, New York 14642
Phone: (585)275-5859
Fax: (585)276-2380

Informed Consent for Cytogenetic Testing

Patient Name: _____ Date of Birth: ___/___/_____ Sex: Female ____ Male____

For more information on FISH testing and probes ordered please visit our website:
https://www.testmenu.com/rochester/Tests/68252

For more information on Chromosome Microarray testing:
https://www.urmc.rochester.edu/pathology-labs/clinical/healthcare-providers/consent-forms.aspx

I request and authorize URMC Labs to perform only the above designated test(s) on the sample from me (or my child or fetus). The signature below constitutes my acknowledgment that the benefits, risks and the limitations of this testing have been explained to my satisfaction by a qualified health care professional. Because of the complexity of genetic testing and the important implications of the test results, results will be reported only through a physician, genetic counselor or other identified health care provider. In addition, to fully understand what the risks and benefits are to having the genetic testing, professional genetic counseling is advised prior to giving consent and upon receipt of results genetic counseling may be advised and is available.

The following has been explained to me:

1. Cytogenetic testing may:
    a. Identify whether there is extra, missing or rearranged genetic material
    b. Diagnose whether or not I have (or my child or fetus has) a particular condition or am at risk for developing this condition.
    c. Identify a chromosomal condition that I did not know I (or my child or fetus) was at risk for
    d. Identify whether or not I (or my child or fetus) am a carrier for this condition
    e. Predict another family member has or is at risk for the condition
    f. Be indeterminate due to technical limitations

2. A positive result is an indication that I (or my child or fetus) may be predisposed to or have the specific disease or condition. Further independent testing may be needed to confirm the diagnosis.

3. There is a chance that I will have a chromosomal condition but the cytogenetic test results will be negative due to the limitations of this technology.

4. Cytogenetic testing results are not intended to be used as the sole means for clinical diagnosis or patient management decisions.

5. Cytogenetic test results are confidential and are released to the ordering health care provider and those parties entitled to them by state and local law.

6. Incidental findings (findings unrelated to the reason for referral) may be discovered. These findings will be reported to the provider for clinical determination.

7. My (or my child's or my fetus') sample may be used for test validation, education, or research after my personal identifiers are removed. Initials:_____ Yes _____No If not specified, no will be considered the default.

8. All samples will be disposed of 60 days after testing is complete per NYS Civil Rights Law section 79-L unless consent is given for validation, education or research use.