Quest Diagnostics Nichols Institute
14225 Newbrook Drive
P.O. Box 10841
Chantilly, Virginia 20153-0841
703-802-6900
800-336-3718
www.questdiagnostics.com

Quest Diagnostics
Nichols Institute-Chantilly
Cytogenetics Laboratory

Fanconi Anemia Sample Submission Form
(Please fill this form out completely and submit with specimen)

Patient Name: _____
Date of Birth: _____ **Sex:** _____

Ordering Physician: _____
Physician Phone Number: (_____)_____
Physician Fax Number: (_____)_____
Contact e-mail address(es): _____
_____

Billing Information/Billing Address:
_____
_____
_____
_____

Mailing Address: (address to send reports)
_____
_____
_____
_____

Specimen Type:

☐ Peripheral Blood	☐ Amniotic Fluid	☐ Chorionic Villi
☐ Fibroblasts	☐ Cultured Amniocytes	☐ Cultured Chorionic Villi
☐ Cultured Fibroblasts		

CVS: Please phone to discuss concerns/issues related to maternal cell contamination (MCC) in CVS. A purple-top (EDTA) tube of whole blood from the patient may be needed to rule out the possibility of MCC.

For **prenatal samples** please check below if G-banded chromosome analysis and/or amniotic fluid AFP testing is desired.

☐ Chromosome analysis
☐ AFP

Number of tubes/flasks: _____
Date/Time of collection: _____

Indication for study (please be as specific as possible):
_____
_____
_____

Additional Information: If this is an identified at risk family, please include all relevant information about any planned follow-up (HLA typing, etc.)
_____
_____
_____

Please include a copy of a signed informed consent for our files **if** available.

FANCONI ANEMIA DEB TESTING INFORMATION

Test Codes: 14598, DEB breakage analysis for Fanconi Anemia, peripheral blood or bone marrow
14259, Prenatal and fibroblast DEB breakage analysis for Fanconi Anemia

(If submitting prenatal order for routine cytogenetics
and/or AF-AFP, test codes 1370 and 7993 will also be billed.)

Cost: Please contact Hospital Sales Support, 800-336-3718 x2300

CPT codes attached to this billing are 88230, 88249, 88291*

* "The CPT codes provided are based on AMA guidelines and are for informational purposes only. CPT coding is the sole responsibility of the billing party. Please direct any questions regarding coding to the payer being billed."

Specimen Requirements:

Prenatal:

25 ml (minimum 15mL) fresh amniotic fluid

40mg (minimum 20mg) chorionic villi submitted in sterile, nontoxic, centrifuge tubes, room temperature.

Minimum Prenatal Cultures: 2 T-25 flasks filled with culture medium, each containing primary or early passage monolayers, room temperature. Please note if fungizone was added to the cell culture media.

Postnatal:

10 ml whole blood in green-top sodium-heparin tube (2-3mL for infants). *Do **NOT** submit a sample within 2 weeks of chemotherapy or radiation therapy and please inform the laboratory of any prior therapy*.

Skin biopsy punch in culture medium or 2 T-25's cultured fibroblasts

Room temperature

Shipping information:

Please send the specimen directly to local Quest Business Unit or the cytogenetics laboratory at the address below. Notify the laboratory of carrier tracking number by phone or e-mail prior to submitting specimen.

ATTN: Aimee Martin, M.S./ Mr. Stephen Wallingford/ Dr. Steven Schonberg
Cytogenetics Laboratory
Quest Diagnostics Nichols Institute, Chantilly
14225 Newbrook Drive
CHANTILLY, VA 20153-0841

Aimee Martin: aimee.d.martin@questdiagnostics.com
Steve Wallingford: stephen.x.wallingford@questdiagnostics.com
Steven Schonberg: steven.a.schonberg@questdiagnostics.com

For any questions regarding the information provided or the testing offered, please call our genetic counselor Aimee Martin, MS, CGC, at 703-802-7148 (1-800-336-3718 ext. 7148),
e-mail aimee.d.martin@questdiagnostics.com or phone 1-866-GENEINFO [866-436-3463]

Quest Diagnostics

Patient Informed Consent for Genetic Testing

I, _____ (Patient's Name) authorize Quest Diagnostics to conduct genetic testing for _____ (Disease and/or Test Name), as ordered by my physician or authorized healthcare provider or my child's or dependent's physician or authorized healthcare provider.

Quest Diagnostics will release the results of the genetic testing only to my physician, or to persons authorized by me or as required by law. I authorize my physician to request on the test order that a copy of my test results be provided by Quest Diagnostics to the following persons:

_____.

Healthcare Provider Statement

By their signature below, the healthcare provider indicates that he or she has explained the purpose of the test, the procedures, the benefits and risks that are involved in testing to their patient. His or her patient has been given the opportunity to ask questions about this consent and seek genetic counseling. The healthcare provider acknowledges that his or her patient has voluntarily decided to have the test performed at Quest Diagnostics.

_____

Signature of Person Obtaining Consent Date

_____

Printed Name of Person Obtaining Consent

Patient's Statement

I, the undersigned, have been informed about the test(s) purpose, procedures, possible benefits and risks, and I have received a copy of this consent. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask other questions at any time. I voluntarily agree to genetic testing.

_____

Signature of Patient Date

_____

Printed Name of Patient

_____

Signature of Parent or Legally Authorized Representative Date

_____

Printed Name of Parent or Legally Authorized Representative Relationship to Patient

For use by clients (at client's request) in: AK, AZ, FL, GA, NH, NJ, NM, OR, VT
Written consent not required in FL and OR.