KNIGHT CANCER INSTITUTE
Oregon Health & Science University
KNIGHT DIAGNOSTIC LABORATORIES

Laboratory Shipping Address: 2525 SW 3rd. Avenue
Suite 350 Portland, OR 97201
Correspondence Address: 3181 SW Sam Jackson Park Road
Mailstop MP-350 Portland, OR 97239
Phone: 855-KDL-1LAB (535-1522) - Fax: 855-KDL-1FAX (535-1329)

Constitutional/Prenatal Cytogenetics Requisition

Patient Information		Client Information	
Name (Last, First, MI):		Ordering Physician Name:	
Address:		Ordering Physician NPI:	
City, State, Zip:		Office/Facility Name:	
Patient Phone:	Fax:	Client Address:	
Patient DOB:	Sex:	City, State, Zip:	
Patient ID/MRN #:		Client Phone:	Fax:
Notes:		Account #:	

Additional Physicians To Receive Report Copy

CC Physician Name:	CC Physician Phone:	Fax:
CC Physician Name:	CC Physician Phone:	Fax:

Billing Information

☐ Bill Insurance (Please Attach Copy of Insurance Card or Billing Face Sheet) ☐ Bill Client (Invoice will be sent to Client Address Listed Above) ☐ Bill Patient

Primary Insurance Company Name: _____ Group # _____ Policy# _____

☐ Medicaid ☐ Medicare (If Medicare denies payment, patient agrees to be personally responsible for charges.) Signature:_____

Relation to Insured : ☐ Self ☐ Child ☐ Spouse ☐ Other _____

Secondary Insurance Company Name: _____ Group # _____ Policy# _____

☐ Medicaid ☐ Medicare (If Medicare denies payment, patient agrees to be personally responsible for charges.) Signature:_____

Relation to Insured : ☐ Self ☐ Child ☐ Spouse ☐ Other _____

Clinical Information

Clinical Diagnosis: (fetal abnormalities, provisional diagnosis, family history of chromosome abnormalities, etc):	ICD-9 (Required):
	Date of Specimen Collection:
	Time of Specimen Collection:

Specimen Type: ☐ Blood, Na Heparin ☐ Blood, EDTA ☐ CVS ☐ Amniotic Fluid

☐ Skin Biopsy ☐ Fibroblasts ☐ Other (Specify):_____

Pregnancy History: G:____ P:____ SAB:____ TAB:____

Gestational Age_____ Determined By_____

WBC:_____

Cytogenetics Microarray

☐ 6500	Microarray Comparative Genomic Hybridization (Requires Na Heparin and EDTA Tubes)

Chromosome Studies

Test Code	Test Name	Test Code	Test Name
☐ 6020	Amniotic Fluid Chromosome Study	☐ 6242	Fibroblast Retrieval
☐ 6050	Blood Chromosome Study	☐ 6750	Tissue Chromosome Study
☐ 6100	Chorionic Villus Sample Chromosome Study	☐ 6054	High Resolution Blood Chromosome Study
☐ 6240	Fibroblast Primary Culture		

*Chromosome studies will reflex to FISH if clinically relevant abnormalities are detected. FISH testing will be billed separately.

Other

Test Code	Test Name
☐ 6240	Freeze and Store Cells

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FISH Assays			
Test Code	Test Name	Test Code	Test Name
☐ 7020	Angelman syndrome (SNRPN/D15S10)	☐ 8762	SNRPN dup(15) in autism
☐ 8105	Cri-du-Chat syndrome (5p-)	☐ 8772	SRY region (Y-chromosome)
☐ 7140	DiGeorge syndrome (TUPLE1)	☐ 8775	Steroid Sulfatase (STS)
☐ 8395	Kallman syndrome (KAL)	☐ 7870	Velocardiofacial syndrome (TUPLE1)
☐ 7510	Miller-Dieker syndrome (LIS)	☐ 7900	Williams syndrome (ELN)
☐ 7020	Prader-Willi syndrome (SNRPN/D15S10)	☐ 7920	Wolf-Hirschhorn syndrome
☐ 8756	SHOX	☐ 8950	X & Y
☐ 7750	Smith Magenis syndrome (SMS)		