PRINT RESET

University of Iowa Diagnostic Laboratories
Department of Pathology
200 Hawkins Drive, 5231 RCP
Iowa City, IA 52242
Client Services Toll Free: (866) 844-2522
Client Services Local: (319) 384-7212
Client Services Fax: (319) 384-7213

UIDL
CONSTITUTIONAL GENETICS
PRE- AND POST-NATAL REQUISITION

REQUIRED INFORMATION IN RED

REFERRING INSTITUTION (CLIENT) INFORMATION

Referring Institution:			**UIDL Client:**		
Requisition Completed By:		Date:			
Address:					
City:		State:		Zip Code:	
Treating Physician:					
Phone:		Fax:			
Referring Pathologist:					
Phone:		Fax:			
Genetic Counselor:					
Phone:		Fax:			

PATIENT INFORMATION

Last Name:		First Name:			
Gender:	☐ Male ☐ Female	Birth Date:			
Address:			Phone:		
City:		State:		Zip Code:	

BILLING INFORMATION — The UIDL only accepts one billing directive

The below link details important information to review before selecting a billing option and submitting a specimen:
https://uidl.medicine.uiowa.edu/billing

Direct Bill

☐ **Referring Institution (Client)**

☐ **Patient's Insurance**

Provide complete and valid information or referring institution may be billed.

On date of collection, was your patient:

☐ Hospital Inpatient ☐ Hospital Outpatient ☐ Non-Hospital Patient

☐ **Patient (Self-Pay)**

Only available to Iowa residents without insurance—Prepayment not required.

Prepayment Required

☐ Non-Iowa Resident with non-Iowa Medicaid or no insurance

SPECIMEN INFORMATION

Collection Date:		Collection Time (HH:MM):	
Body Site:		Specimen Source:	
Specimen Type:	☐ Paraffin Embedded Tumor Tissue	☐ Peripheral Blood (post-natal)	
	☐ Products of Conception (POC)		
	☐ Other*, please specify:		

* **Nucleic acid (NA) extract**—before ordering testing, please review https://medicine.uiowa.edu/uidl/nucleic-acid-extracts for UIDL compliance requirements, and contact the laboratory for additional specimen details (e.g., concentration, elution buffer, transport instructions, etc.) and approval.
UIDL may accept NA extract provided it is: 1) an acceptable specimen type; and 2) isolated in a CLIA-certified laboratory or a laboratory meeting equivalent requirements prescribed by the Centers of Medicare and Medicaid Services (CMS). **REQUIREMENT**: A valid copy of your institution's CLIA certificate, or certificate recognized by CMS.

CLINICAL INFORMATION — Please include a copy of your report

Diagnosis/ICD-10 Code(s):	1.	2.	3.	4.	5.	6.

Pertinent Clinical History and Findings:

TEST REQUEST — SELECT ALL THAT APPLY

CYTOGENETICS

☐ CMA, Chromosomal Microarray — LAB8257 Peripheral Blood: Lavender top, EDTA (<1 yr.: 1-2 ml; >1 yr.: 3-5 ml) Tissue (POC): Sterile Container	☐ Karyotype, Chromosome Analysis — LAB8256 Peripheral Blood: Green top, Sodium Heparin Tissue (POC): Sterile Container

FISH — LAB8258

☐ Aneuploidy Screen (21, 18, 13, X and Y)	☐ SRY (Yp11.3)
☐ Other individual FISH probe(s)*, please specify:	

* Please contact the Cytogenetic Laboratory, (319) 356-3877, with questions specific to FISH probes.

MOLECULAR

☐ FMR1 Gene Analysis Characterization of Alleles with Interpretation (Fragile X) — LAB2460