UIDL
U I Diagnostic Laboratories

MOLECULAR GENETICS

GENERAL CONSULT REQUISITION

UI Diagnostic Laboratories
Department of Pathology
200 Hawkins Drive, 5231 RCP
Iowa City, Iowa 52242
Toll Free: 866-844-2522
Local: 319-384-7212
Fax: 319-384-7213

FOR CLIENT USE ONLY Requisition Date:
Completed By: Accn#:

FOR UIDL USE ONLY UIDL Accn #:
UIDL MRN #:

PART A - PATIENT INFORMATION - *Required*

Patient Name:
Street:
City: St: Zip:
Phone: ( )
Date of Birth: Gender: ☐Male ☐Female

PART B - PROVIDER INFORMATION - *Required*

Referring Facility:
Street:
City: St: Zip:
Phone: ( ) Fax: ( )
Ordering/Contact Physician: NPI: Phone:
Genetic Counselor (if known): Phone:

PART C - SPECIMEN INFORMATION (Complete the appropriate information below or include in an accompanying letter.)

SPECIMEN COLLECTION DATE: **SPECIMEN COLLECTION TIME:**

SPECIMEN TYPE: ☐ **EDTA Whole Blood** ☐ **DNA** ☐ **Other (Specify):**

Required ICD-9 codes: 1. 2. 3. 4.

PERTINENT CLINICAL HISTORY AND FINDINGS (please attach pedigree if available):

SELECT TEST:

☐**Angelman Syndrome (methylation)**
☐**Factor 5 Leiden/Factor 2 g.20210G>A**
☐**Familial Partial Lipodystrophy, Dunnigan type, FPLD2 (*LMNA* sequencing)**
☐**Fragile X Syndrome**
☐**Hemochromatosis, Hereditary**
☐**Huntington Disease (Requires HD Indication Form)**
☐**Hutchinson-Gilford Progeria Syndrome, HGPS (*LMNA* sequencing)**
☐**Mandibuloacral Dysplasia with Type A Lipodystrophy, MADA**
☐**Parkinson Disease-8 (*LRRK2*, p.G2019S)**
☐**Prader-Willi Syndrome (methylation)**
☐**Restrictive Dermopathy (*LMNA* sequencing)**
☐**Transforming Growth Factor Beta Receptor 2, exon 5, (R460C)**

This request to order molecular diagnostic tests from University of Iowa Diagnostic Laboratories (UIDL) certifies to UIDL that the ordering physician has obtained informed consent from the patient as required by applicable state or federal laws for each test ordered and that the ordering physician has authorization from the patient permitting UIDL to report results for each test ordered to the ordering physician.

Genetic Counseling and Information: By requesting testing, the ordering physician assumes responsibility for providing the patient with all associated guidance and counseling regarding the test results. Alternatively, patients can be referred to qualified counseling services by contacting our client service line at ph.: (866)844-2522.

Refer to the UIDL TEST DIRECTORY for specimen requirements and CPT Code information.

PART D - SEND BILL TO:
(Required)

☐ **Referring Institution** Contact Person: ______________________
Address: ______________________
City, State, Zip______________________
Phone: ____________ Fax: ____________E-mail: ____________

☐ **Patient's Insurance** (Complete billing information must be provided or referring institution may be billed)
(Required information is in red)

Please note that the **correct birth date of all policy holders** is required information. Please attach the following to the requisition:

(1) a copy of the front/back of patient's insurance card(s). Please designate primary vs. secondary/tertiary coverage.

OR

(2) a printout with patient demographics and insurance information from your practice management system.

Medicare will only pay for the services that it determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under the Medicare standards, Medicare will deny payment for that service or test.

The purpose of this form is to obtain information necessary for the Pathology Department to perform consultations and/or testing. Failure to properly complete the form may cause delay in the processing of specimens.