



MOLECULAR GENETICS
General Consult Requisition

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 Client Code: _____		Requisition Date: _____		Completed by: _____	
REQUIRED INFORMATION IN RED					
PART A – PATIENT INFORMATION			PART B – PROVIDER INFORMATION		
Patient Last Name: _____			Referring Institution: _____		
Patient First Name: _____			Street: _____		
Street: _____			City: _____		St: _____ Zip: _____
City: _____			Phone: _____		Fax: _____
Phone: _____		Fax: _____		Referring Physician: _____	
Date of Birth: _____		Gender: M F		Referring Physician Phone: _____	
PART C - SPECIMEN INFORMATION (Complete the appropriate information below or include in an accompanying letter.)					
Date Collected: _____		Time Collected: _____		Specimen: EDTA Whole Blood DNA Other: _____	
ICD-10 codes: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____					
PERTINENT CLINICAL HISTORY AND FINDINGS (please attach if available):					
<p>SELECT TEST: Refer to the UIDL TEST DIRECTORY for specimen requirements and CPT Codes at https://www.healthcare.uiowa.edu/path_handbook/rindex.html</p> <p><input type="checkbox"/> Coagulation Factor 2 [LAB9068] <input type="checkbox"/> Factor 5 Leiden Mutation & Factor 2 20210G>A Variant with Interpretation [LAB346] (Requires ABN) <input type="checkbox"/> FMR1 Gene Analysis Characterization of Alleles with Interpretation [LAB2460] <input type="checkbox"/> HFE Hemochromatosis Gene Analysis Common Variants with Interpretation [LAB2466] <input type="checkbox"/> Leiden Variant Factor 5 [LAB9067] <input type="checkbox"/> MTHFR Mutation Analysis with Interpretation [LAB8464]</p> <p>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.</p> <p><u>Genetic Counseling and Information:</u> By requesting testing, the ordering physician assumes responsibility for providing the patient with all associated guidance and counseling regarding test results.</p>					
PART D – BILLING			NOTE: Claims can't be submitted to a Medicaid Program Outside of Iowa		
On date of collection, was patient:			Admission Date: _____ Discharge Date: _____		
<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Non-Hospital Patient - Facility name where specimen collected: _____					
<input type="checkbox"/> No Valid Insurance- Self Pay Iowa Resident <input type="checkbox"/> No Valid Insurance- Self Pay NON Iowa Resident: Prepayment required before test order can be accepted. Call 866-844-2522 to arrange payment.					
<input type="checkbox"/> Bill Client Email Recipient for Invoicing _____ Name: _____ Phone: _____					
<input type="checkbox"/> Bill Insurance PRE-AUTHORIZATION #: _____ Required for all out of state cases. See website for a comprehensive guide to UIDL Billing - https://uidl.medicine.uiowa.edu/billing					
Primary Insurance Coverage Information			Secondary Insurance Coverage Information		
Insured by: _____			Insured by: _____		
Claims Address: _____			Claims Address: _____		
City: _____		St: _____	City: _____		St: _____
Policy/ID #: _____		Group #: _____	Policy/ID #: _____		Group #: _____
Name of Subscriber: _____		DOB: _____	Name of Subscriber: _____		DOB: _____
Relationship to Patient: _____			Relationship to Patient: _____		

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