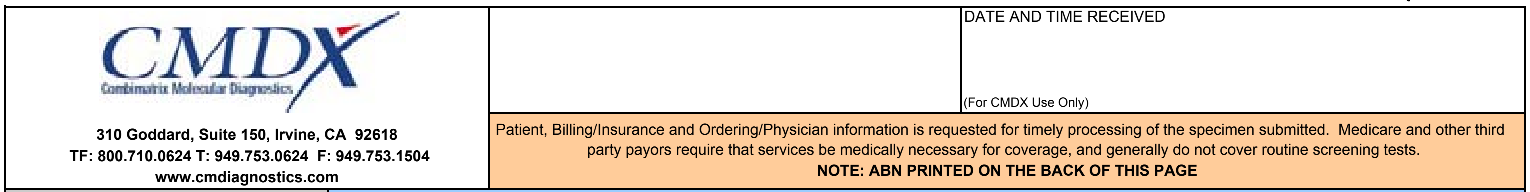
COMPLETE REQUISITION



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www.cmdiagnostics.com

DATE AND TIME RECEIVED

(For CMDX Use Only)

Patient, Billing/Insurance and Ordering/Physician information is requested for timely processing of the specimen submitted. Medicare and other third party payors require that services be medically necessary for coverage, and generally do not cover routine screening tests.
NOTE: ABN PRINTED ON THE BACK OF THIS PAGE

1. Patient Information

Have any family members previously been tested at CMDX? ☐ Yes ☐ No If yes, whom?

Last Name	First	Middle	SSN
Street Address	City, State Zip		
Telephone #	Date of Birth	☐ Male ☐ Female	Medical Record Number (MRN)

2. Billing/Insurance Information

( ) Ordering Institution ( ) 3rd party (Insurance) - **Attach copy of card** ( ) Self-Pay - Attach Payment Options form

Please complete billing information below and **enclose copies of insurance information**. Complete billing information must be provided or ordering institution may be billed.

Authorization Number
(For CMDX use only)

☐ **Insurance** Carrier: ______ Member ID# ______ Group#: ______
Address: ______ City, State Zip ______
Insured Name: ______ SSN: ______ Relationship to patient: ______

3. Ordering Institution Information

Institution Name			Address:
Phone	Fax		
Contact Name	Email	Phone	Secure Fax

4. Physician Information - Reports will be sent to physicians listed below at fax # provided.

Ordering Physician Name		Referring Physician Name		Fax Additional Reports to: UCSF Clinical Labs	
Specialty	**UPIN/NPI#**	Specialty	UPIN/NPI#	Specialty	UPIN/NPI#
Phone ( )		Phone ( )		Phone (415) 353-1349	
Fax ( )		Fax ( )		Fax (415) 353-4824	

5. Specimen Information

Specimen ID# | # of Samples

☐ Peripheral Blood ☐ Skin biopsy ☐ Chorionic Villi ☐ Amniotic Fluid
☐ DNA ☐ POC ☐ Tissue Biopsy: __________

Collection Date: | Collection Time

6. Clinical Information ☐ Report enclosed. ☐ No report enclosed.

LMP:__________ Pregnant: Yes No Gest Age: ________ wks________days

Clinical Diagnosis/Reason for Referral:

ICD9 Code(s):

7. CMDX Test Menu

We accept specimens Monday-Saturday, 8am-5pm PST

		Test	CPT Codes
Oligo	☐	Oligo HD Scan™ - High Density Constitutional Array	83891(x2), 88386(x5)
	☐	AT Scan™ (Oligo HD Scan™ with Autism Spectrum Disorder (ASD) detection)	83891(x2), 88386(x5)
BAC	☐	Prenatal Scan™ - High Density Constitutional Array *	83891(x2), 88386(x5)
	☐	BAC HD Scan™ - High Density Constitutional Array	83891(x2), 88386(x5)
	☐	AT Scan™ (BAC HD Scan™ with Autism Spectrum Disorder (ASD) detection)	83891(x2), 88386(x5)
	☐	HemeScan™ ☐ CLL ☐ ALL ☐ MDS ☐ MPD	83891(x2), 88386(x4)
	☐	HerScan™ (for Breast Cancer) **DNA only, see Specimen Requirements	83891(x2), 88386(x4)
FISH	☐	FISH (Fluorescence In Situ Hybridization)	-Contact Client Services

8. Level of Service**

***Note: If Level of Service is not indicated, sample will be processed as GLOBAL.**

☐ Technical Only Program (TOP) ☐ Technical + Global Report (Full Service)

9. Comment Section (Special Requests/Questions)

10. Required Signature

☐ By my signature below, I certify that the above ordered molecular analysis is reasonable and medically necessary for the diagnosis, care and treatment of the this patient's condition.

☐ By my signature below, I certify that Combimatrix Molecular Diagnostics (CMDX) has permission to perform testing on my or my child's sample.

Signature	Print Name	Date

ASR-F-025-009 Rev. 7/28/08

**Note: *Please provide parental peripheral blood along with the prenatal sample; see Specimen Requirements for more information.
Please include any previous genetic reports.**

Specimen Label Instructions:

1) Complete the requisition with all requested information. (**Highlighted areas are required**) 2) Remove the proper number of labels. 3) Place one label on each specimen container (not on the lid).