Laboratory of Personalized Genomic Medicine
Department of Pathology and Cell Biology

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Columbia University
College of Physicians and Surgeons

Precision Genomics Laboratory

701 West 168th Street, HHSC 1401A
New York, New York 10032
Tel: 212-305-6094 Fax: 212-305-6687

Maternal Fetal Medicine Requisition

Must be filled out completely. Informed Consent MUST be signed by Patient, Parent/Legal Guardian or Legal Next of Kin.

Sample Info

DATE COLLECTED (MM/DD/YY) | TIME COLLECTED AM PM

DATE SENT | FROZEN ☐ YES ☐ NO

COLLECTED BY

Patient Information

LAST NAME | FIRST NAME | M.I.

DATE OF BIRTH (MM/DD/YY) | MRN | SEX ☐ MALE ☐ FEMALE

ADDRESS

CITY/STATE/ZIP

HOME PHONE | WORK PHONE

Ordering Physician Information

CLINICIAN NAME | EMAIL

INSTITUTION | TELEPHONE NUMBER

ADDRESS | CITY/STATE/ ZIP

SIGNATURE | DATE

NOTE TO HEALTH CARE PRACTITIONER: It is New York State Law and Columbia University Policy that an informed consent is obtained prior to performing genetic predisposition testing and maintained in the patient's medical record. Please use the appropriate disease/gene information/informed consent sheet, ensure that the patient/legal guardian understands its contents, and obtain the person's signature. If the patient consents to having the sample retained in the lab for greater than 60 days, please include a copy of the consent form with this requisition. **I have obtained a signed informed consent to perform genetic testing in accordance with New York State Civil Rights Law, 79-L, and the informed consent is retained in the patient's medical record.:** ☐

Clinical Information

ETHNICITY ☐ ASIAN ☐ AFRICAN - AMERICAN ☐ CAUCASIAN ☐ HISPANIC ☐ JEWISH, ASHKENAZI ☐ JEWISH, NON - ASHKENAZI ☐ OTHER

Family History of Genetic Condition? (1st, 2nd, or 3rd degree relative) ☐ YES ☐ NO
SPECIFY CONDITION _____

Is patient pregnant? ☐ YES ☐ NO

Is patient on oral contraception? ☐ YES ☐ NO

MATERNAL WEIGHT LBS | DUE DATE (MM/DD/YY) | Is patient insulin-dependent diabetic? ☐ YES ☐ NO

GESTATIONAL AGE WEEKS DAYS | CALCULATED ON DATE (MM/DD/YY) | DATING METHOD ☐ LMP ☐ U/S

Multiple gestation pregnancy? ☐ YES ☐ NO ☐ UNKNOWN

Did patient use an egg donor? ☐ YES ☐ NO AGE OF DONOR _____

Did patient use a surrogate? ☐ YES ☐ NO

Insurance Information

NAME OF INSURED | DATE OF BIRTH

RELATIONSHIP TO PATIENT: ☐ SELF ☐ PARENT ☐ SPOUSE ☐ CHILD ☐ OTHER

NAME OF INSURANCE COMPANY:

ADDRESS

POLICY #: | GROUP #:

PREAUTHORIZATION: If health insurance preauthorization is required, check here if preauthorization is pending: ☐

INSTITUTIONAL BILLING (CLINICIAN): Do you have a PGM Billing Account?
☐ Yes P.O. #_____
☐ No (Email Pathology-billing@columbia.edu to establish an account)

CREDIT CARD (PATIENT): I have provided my credit card information to the Pathology Billing Office (call 212-305-7399 to provide card information). ☐

MEDICARE PATIENTS ONLY: Check here to confirm that an Advance Beneficiary Notice (**ABN**) was signed by the Patient: ☐

GENETIC CARRIER SCREENING

☐ **Cystic Fibrosis* ONLY**

☐ **Spinal Muscular Atrophy (SMA) ONLY**

☐ **Thrombophilia Risk Panel 1**
Factor V Leiden
Prothrombin 20210G>A

☐ **Thrombophilia Risk Panel 2**
Factor V Leiden
MTHFR Mutations
Prothrombin 20210G>A

☐ **FMR1 - Fragile X ONLY**

☐ **EXPANDED SCREENING:** Cystic Fibrosis + SMA + Fragile X

☐ **Familial Confirmation Testing / Sanger Sequencing of Targeted Gene**

GENE: _____ VARIANT OF INTEREST: _____

To order individual test components not listed above, please contact PGMinquiry@cumc.columbia.edu.

*This assay will be performed in the Precision Genomics Laboratory.

CLINICAL INDICATIONS

Ordering Clinician should report the diagnosis that best describes the reason for performing the test. Mark all that are appropriate.

☐ Screening for genetic disease carrier status
☐ Testing of female for genetic carrier status
☐ Testing of male for genetic carrier status
☐ Screening for Cystic Fibrosis
☐ Other genetic screening
☐ Family history of genetic disease carrier
☐ Pregnant state, incidental
☐ Family history of other musculoskeletal disease
☐ Supervision of normal first pregnancy
☐ Supervision of other normal pregnancy

ICD 10:

COLLECTION REQUIREMENTS *(Samples not to exceed 3 tubes, regardless of testing)*

Cystic Fibrosis ..... (1) 4 mL Lavender-top EDTA Tube
Spinal Muscular Atrophy ..... (1) 4mL Lavender-top EDTA Tube
Fragile X ..... (1) 4mL Lavender-top EDTA Tube
Expanded Screening: CF, SMA, FX ....(2) 4mL Lavender-top EDTA Tubes
Thrombophilia Risk Panel ..... (1) 4mL Lavender-top EDTA Tubes
Familial Confirmation Testing ..... (1) 4mL Lavender-top EDTA Tubes