Laboratory of Personalized Genomic Medicine
Department of Pathology and Cell Biology

630 W. 168th Street, P&S 17 Floor, Room 401
New York, NY 10032
Tel: 212-305-9706 Fax: 212-342-0420

COLUMBIA UNIVERSITY
Vagelos College of Physicians and Surgeons
Precision Genomics Laboratory

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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 Information

Date Collected (MM/DD/YY):
Time Collected: ☐ AM ☐ PM
Date Sent (MM/DD/YY):
Frozen: ☐ Yes ☐ No
Collected By:

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.**

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:	

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 and egg donor? ☐ Yes ☐ No Age of Donor: ____
Did patient use a surrogate? ☐ Yes ☐ No

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Insurance Information

Name of Insured:

Date of Birth (MM/DD/YY):

Relationship to Patient: ☐ Self ☐ Patient ☐ Spouse ☐ Child ☐ Other

Name of Insurance Company:

Address:

Policy Number: Group Number:

☐ **Preauthorization:** Check here if health insurance preauthorization is required, check here if preauthorization is pending

Institutional Billing (Clinician): Do you have a PGM

Do you have PGM Billing Account? ☐ Yes, P.O. Number
☐ No (Email pathology-billing@columbia.edu to establish an account)

☐ **Credit Card (Patient):** Check here if you have provided 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 Patients

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