Constitutional Cy		ics Requ	isition (non-can	cer)			T S O		VESTERN	
Medi		allas Referra	als Lab	5323 Harry Hines	Blvd U5.1				CENTER	
Account name:	1 '	Dallas, Texas 75390								
Address: 7777 Fores	PHONE: 214-645 Toll Free: 877-88			VERIF	PATH LAB	ORATORIES				
Zip code: 75230 P	h: 972-56	6-2678 _{Fa}	972-566-2174	FAX: 214-645-70						
DECLUBED ORDER	REQUIRED ORDER INFORMATION					CLIA #45D-0659587, CAP #2723201 www.veripathlabs.com				
A Facility / C		IION		PATIENT/3RD	PARTY	BILLING	INFORI	MATION		
BILL 10:		ng information	must be provided	` '						
Patient Name: (Last, First, Middle)				Medicare patients with Beneficiary Notice (AB	N) available	at www.veripa	thlabs.com	vanced or by calling	☐ Signed ABN included	
Mother's Name: (if infant)				ICD-9 Codes applicable to	o each and e	very test reques	sted should co		ne ordering physician,	
Date of Birth: Sex:		Patient ID / MR#	#:	represent the reason for t	only tests that	t are medically r	necessary for	the diagnosis or	r treatment of the patient.	
	la		I	Tests ordered should be s screening purposes may	be ordered, b	out may not be r	eimbursed.	alient's medica	i condition. Tests for	
Hospital Inpatient Y / N	Collection Date:	1	Collection Time: AM PM	Insured/Responsible Part	y Name: (if o	different from pa	tient-Last, Fire	st, Middle)	Date of Birth:	
Ordering Physician (Full Name):		NPI:		Patient's relationship:	Responsible Party Address: (street, city, State, zip)					
Phone:	Pager:	FAX:		□ Self □ Spouse						
				☐ Dependent ☐ Other						
Clinical Indication for Tests Ordered:				Sex:	Phone:					
SPECIMEN INFORM	IATION			Employer's Name:	1			Employer's Pl	hone:	
□Blood PR			REGNANT PATIENTS	Insurance Co. Name:		Insurance Co. Pho		Phono:		
□Amniotic fluid LMP_			MP					insurance Co.	. Filone.	
□CVS Gest age by ultrasound:				Insurance Co. Address:	Insurance Co. Address:					
□PUBS	wksdays		Policy #:	Policy #:		Group #:				
□Products of conception							Member ID#	4.		
☐Tissue: site/type	I	I wedicare I mile I other								
□ Other:				Referral Authorization/Pre	ecertification					
DIAGNOSTIC INFOR	RMATION			Name:			Date/Time:			
PRENATAL:		POSTNATA	L - suspected diagnosis:	Check at least one	e sympto	om:				
□Advanced maternal	age	□Down synd	drome	□Ambiguous genita	alia	□Multiple		ages		
□Advanced maternal	age ve for:	□Down synd □Trisomy 13	drome 3		alia	□Multiple □Short st	ature		mal anomaly	
□Advanced maternal	age ve for:	□Down synd	drome 3 3	□Ambiguous genita	alia alies	□Multiple □Short st □Family I	ature nistory of	chromoso	mal anomaly	
□Advanced maternal at □Serum screen positive Down syndrome NTD (increased Months of the Trisomy 18	age ve for: (SAFP)	□Down synd □Trisomy 13 □Trisomy 18	drome 3 3	□ Ambiguous genital □ Congenital anoma □ □ Developmental de	alia alies ——— elay	□Multiple □Short st □Family I	ature nistory of nistory of	chromoso	l anomaly	
□Advanced maternal and Serum screen position □ Down syndrome □ NTD (increased Moreover) □ Trisomy 18 □ Other:	age ve for: //SAFP)	□ Down synd □ Trisomy 13 □ Trisomy 18 □ Turner syn □ Other *Mosaicism scr	drome 3 3 adrome* reen (additional cell counts)	□ Ambiguous genita □ Congenital anoma □ □ Developmental de □ Fetal demise/mise	alia alies ——— elay	□Multiple □Short st □Family I	ature nistory of nistory of	chromoso	l anomaly	
□Advanced maternal and Serum screen position Down syndrome NTD (increased Material and Trisomy 18	age ve for: //SAFP)	□ Down synd □ Trisomy 18 □ Trisomy 18 □ Turner syn □ Other ■ *Mosaicism scr will be performe when routine st	drome 3 3 drome* reen (additional cell counts) ed at an additional charge tudy is normal for suspected	□ Ambiguous genital □ Congenital anoma □ □ Developmental de	alia alies ——— elay	□Multiple □Short st □Family I □Family I	ature history of history of	chromoso	l anomaly	
□Advanced maternal and screen positives. □ Down syndrome of NTD (increased Notes.) □ Trisomy 18 other: □ □Abnormal fetal sonotes.	age ve for: //SAFP)	□ Down synd □ Trisomy 18 □ Trisomy 18 □ Turner syn □ Other *Mosaicism scr will be performe	drome 3 3 drome* reen (additional cell counts) ed at an additional charge tudy is normal for suspected	□ Ambiguous genita □ Congenital anoma □ □ Developmental de □ Fetal demise/mise	alia alies ——— elay	□Multiple □Short st □Family I □Family I	ature history of history of	chromoso	l anomaly	
□ Advanced maternal at □ Serum screen positive Down syndrome NTD (increased Northead and the syndrome NTD) Abnormal fetal sonorthead and the syndrome NTD (increased NTD) (increas	age ve for: ISAFP) gram	□ Down synd □ Trisomy 18 □ Trisomy 18 □ Turner syn □ Other ■ *Mosaicism scr will be performe when routine st	drome 3 3 drome* reen (additional cell counts) ed at an additional charge tudy is normal for suspected	□ Ambiguous genital □ Congenital anoma □ □ Developmental de □ Fetal demise/mise □ Infertility	alia alies ——— elay	□Multiple □Short st □Family I □Family I	ature history of history of	chromoso	l anomaly	
□ Advanced maternal a □ Serum screen positiv	age ve for: ISAFP) gram sis	□ Down synd □ Trisomy 18 □ Trisomy 18 □ Turner syn □ Other *Mosaicism scr will be performe when routine st Turner syndron	drome 3 3 adrome* reen (additional cell counts) ed at an additional charge tudy is normal for suspected ne.	□ Ambiguous genita □ Congenital anoma □ □ Developmental de □ Fetal demise/mise □ Infertility FISH TESTS	alia alies ————————————————————————————————————	□Multiple □Short st □Family l □Family l □Other:	ature nistory of nistory of	chromoso	l anomaly	
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□ Advanced maternal a □ Serum screen positiv	age ve for: MSAFP) gram sis sis with FISI	□ Down synd □ Trisomy 18 □ Trisomy 18 □ Turner syn □ Other *Mosaicism scr will be performe when routine st Turner syndron	drome 3 3 adrome* reen (additional cell counts) red at an additional charge tudy is normal for suspected ne. FISH)	□ Ambiguous genita □ Congenital anoma □ □ Developmental de □ Fetal demise/mise □ Infertility FISH TESTS Aneuploidy: □	alia alies alies elay carriage	□Multiple □Short st □Family l □Family l □Cother: □dy Panel (nistory of nistory of nistory of NX/Y 13, 18, 2	chromoso congenital	l anomaly	
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