



Clinical Molecular and Genomic Pathology

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Chromosomal Microarray Test Requisition Form

Patient Information

First Name: _____ Last Name: _____
Address: _____

Phone: _____
MR#: _____
DOB#: _____
Gender Male Female
Ancestry: Caucasian African American
Hispanic Asian
Native American Others: _____

Official Use Only

Received by: _____
Complete Incomplete
Patient info
Clinical history
Physician info
Billing info
Preapproval required Yes No
Preapproved Yes No
If Medicaid/Medicare, medical necessity provided
Yes No
Comments: _____

Sample Information

Specimen Type
Peripheral blood (EDTA)
Collection Date: _____ Time: _____
Collector: _____
***Phlebotomist must initial tube to confirm sample identity**
Comments: _____

Billing Information

Institutional Bill
Commercial Insurance
Patient Bill
Medicaid/Medicare
Note:
➤ Provide all billing related information
➤ For commercial insurance, preapproval required. Test will not be performed until preapproval is obtained
➤ For Medicaid/Medicare, medical necessity should be provided

Clinical Information

Diagnosis: _____
Previous cytogenetic results, if any: _____

Clinical and Family history, including suspected or known consanguinity: _____

(Attach copies, if needed)

Referring Physician

Name: _____
Address: _____

Phone: _____ Fax: - _____
Email: _____
Requesting Physician/Genetic Counselor/Other Contact name: _____
Phone: _____ Email: _____
Referring physician Signature (Required): _____

Please check all that apply. This information is crucial for clinical interpretation of CMA results.

Perinatal History:

Prematurity
Intrauterine Growth Retardation
Oligohydramnios
Polyhydramnios
Other: _____

Growth:

Failure to thrive
Overgrowth
Short stature
Other: _____

Development:

Fine motor delay
Gross motor delay
Speech delay
Other: _____

Cognitive:

Learning disability
Intellectual disability
Other: _____

Behavioral:

Autism
Autism spectrum disorder
Psychiatric abnormality
Other: _____

Neurological:

Ataxia
Dystonia
Chorea
Hypotonia
Hypertonia
Cerebral palsy
Encephalopathy
Neural tube defect
Seizures
Spasticity
Structural brain anomaly
Other: _____

Cardiac:

Atrial septal defect
Ventricular septal defect
Hypoplastic left heart
Coarctation of aorta
Tetralogy of Fallot
Other: _____

Craniofacial:

Cleft lip
Cleft palate
Coloboma of eye
Craniosynostosis
Dysmorphic facial features
Ear malformations
Macrocephaly
Microcephaly
Other: _____

Musculoskeletal:

Contractures
Club foot
Diaphragmatic hernia
Limb anomaly
Polydactyly
Scoliosis
Syndactyly
Vertebral anomaly
Other: _____

Cutaneous:

Hyperpigmentation
Hypopigmentation
Other: _____

Gastrointestinal:

Gastroschisis
Hirschsprung disease
Omphalocele
Pyloric stenosis
Tracheoesophageal fistula
Other: _____

Genitourinary:

Ambiguous genitalia
Hydronephrosis
Hypospadias
Kidney malformation
Undescended testis
Urethral obstruction
Other: _____