CYTOGENETICS REQUEST FORM

WOMAN'S HOSPITAL PATHOLOGY LABORATORY
100 WOMAN'S WAY • BATON ROUGE, LA 70817 • PHONE: 225-924-8271
ACCREDITED WITH CAP, JCAHO • CLIA#1900463036
PATHOLOGISTS: Drs. Robert Koscick, Beverly Ogden

*All specimens should be transported to the laboratory within **24 hours** after collection. Advance notice is required for all specimens which must be collected or will arrive on **Saturday** or **Sunday**. Any questions please call the Cytogenetics Department at (225) 924-8516 or (225) 924-8474.*

Service (Order) Date:	**Time:**	**Collection Date:**	**Time:**
Referring Institution:			
Ordering Physician:		**Pathologist (if applicable):**	

TYPE OF SPECIMEN *** REQUIRES PRIOR-AUTHORIZATION***

☐ **TISSUE** ☐Chromosome Study Source:	☐ **Her2/neu** Block ID: Source:
☐ **BLOOD** ☐Genetic Abnormality ☐Hematologic Disorder	☐ **URINE (Urovysion)** Specimen ID: Source:
☐ **BONE MARROW or CORE BIOPSY** ☐ Chromosome Study	☐ **MDM2** Block ID: Source:
☐ **OTHER:**	☐ **POC** ☐ Molar ☐ FISH (Aneuvysion)

DIAGNOSIS CODE (Reason for Study):

PATIENT INFORMATION (must be completed)

Patient Name:			**SS#:**
Date of Birth:	**Age:**	**Sex:** ☐Male ☐Female	**Contact Phone #:**
Street Address:		**City, State, Zip:**	

BILLING INFORMATION ** (Attach Insurance Information and Drivers License ONLY when choosing "patient's insurance")**

BILL TO:

☐ **Client/Hospital Account**
☐PGL (2518) ☐OLOL (2514) ☐OLOL-Ascen. (2516) ☐BRG-BB (1514) ☐BRG-MC (1513) ☐Lane (2410)

☐ **PGL** (Specimen originated from: SSC, CPSH, St. James Hospital, or St. Helena Hospital)

☐ **Patient's Insurance** (Specimen originated from: Vivere Audubon, Advanced Surgical Care, Advanced Surgical Concepts, BRASS, Lake Surgery, or OLOL Ponchartrain)

Responsible Party Name:		Relationship:
Patient Address:		Contact Number:
City:	State:	ZIP:

For insurance filing, please attach a legible copy of both sides of the patient's insurance/Medicare/Medicaid card(s) and complete the subscriber information below.

SS#:	Date of Birth:
Relationship to Patient:	

Assignment of Insurance Benefits and Authorization to Pay Insurance Benefits
I hereby assign to Woman's Hospital the insurance benefits herein specified. I also authorize and request payment to be made directly to Woman's Hospital for the hospital insurance benefits specified and otherwise payable to me, but not exceed the Hospital's regular charges for this period of hospitalization. I understand I am financially responsible to the Hospital for all charges not paid by insurance.

Date:	Witness:	Insured:

PHYSICIAN'S SIGNATURE _____ *(NO STAMPS)* **DATE:** _____