



BIOCHEMICAL GENETICS LABORATORY REQUISITION FORM

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1/2002

PATIENT DATA

PATIENT NAME: _____
DOB: ____/____/____
ADDRESS: _____
CITY, STATE, ZIP: _____
PHONE #: _____
HOSPITAL #: _____ ACCESSION#: _____

REFERRING HOSPITAL

HOSPITAL NAME: _____
ADDRESS: _____
CITY, STATE, ZIP: _____
PHONE #: _____ FAX#: _____

REFERRING PHYSICIAN

NAME: _____ UPIN#: _____
ADDRESS: _____
CITY, STATE, ZIP: _____
PHONE #: _____ FAX#: _____

BILLING INFORMATION

Must be completed prior to sample acceptance by lab.

If this section is incomplete, the referring physician or hospital/laboratory will automatically be billed.

PAYMENT METHOD:

- Self-Pay** (*Discounted fees for full payment with sample*)
 - Check or Money Order
 - CC (AMX/MC/VISA) Account #: _____ Exp date: _____
Cardholder name: _____
Cardholder signature: _____
- Referring Institution or MD**
Provide previously assigned code, or complete information below:
Institution Code (as previously assigned): _____
(or) Institution Name: _____
Financial Contact: _____
Billing Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____
- Insurance** (*Insurance cannot be filed without the HMO authorization and ICD-9 code*)
HMO, PPO, Commercial Ins - provide front/back copy of insurance card.
Texas Medicaid - provide current Texas Medicaid form 3087.
Texas Medicaid Managed Care - Authorization / current Texas Medicaid form 3087.
ICD-9 CODE: _____ Patient's diagnosis code must be provided.
Insured's Name: _____
Insured's SS #: _____ Authorization #: _____
Group: _____
Insurance Name: _____
Employer: _____
Insurance Address: _____
Insurance City, State, Zip: _____
Insurance Phone #: _____

Authorization to release information, assign benefits, and accept financial responsibility for my account.

I authorize any physician or lab who has treated me or my dependent(s) to furnish any medical information requested. In consideration of services rendered, I transfer and assign any benefits of insurance to Baylor College of Medicine's, Dept. of Molecular & Human Genetics. I understand I am responsible for any co-pay or deductible amounts if the Dept of Molecular & Human Genetics is a participant with my health plan. I understand I am fully responsible for payment of my account balance if the Dept. of Molecular & Human Genetics is not a participant with my health plan, and my health plan does not reimburse (or only partially reimburses) my medical services due to lack of authorization or medical necessity.

Signature _____ Date _____

4. **Title V Billing**

SAMPLE TYPE

Date Sample Obtained: ____/____/____
 Serum or Plasma Chorionic Villus Amniotic Cells
 Heparinized Blood Urine Chorionic Villus Cells
 Amniotic Fluid CSF Fibroblast Culture
 Tissue: _____

ANALYTE TEST REQUESTED

- Amino Acids (Quantitative)
 - Plasma or Serum
 - Amniotic Fluid
 - CSF
 - Urine
- Acylcarnitine Profile - Bloodspot Card
- Carnitine, Free and Total - Plasma
- Carnitine Combination Panel - Plasma
- Creatine/Guanidinoacetate Analysis - Plasma
- Cystine - White Blood Cell
- Homocysteine, Total Plasma
- Methylmalonic Acid - Plasma
- Mucopolysaccharide Screen - Urine
- Organic Acids - Urine
- Orotic/Orotidine Analysis - Urine
- Phenylalanine/Tyrosine - Serum, Plasma, or Bloodspot
- Purine Panel - Urine
- Sterol Panel - Plasma
- Succinylacetone - Urine

ENZYME TEST REQUESTED

- Tay-Sachs Carrier Testing
- Alpha-N-acetylglucosaminidase (Sanfilippo B Mucopolysaccharidosis)
- Acid Lipase (Wolman & Cholesterol Ester Storage)
- Adenine Phosphoribosyl Transferase (2,8-DHA Urolithiasis)
- Adenosine Deaminase (Adenosine Deaminase Deficiency)
- Arginase (Argininemia)
- Argininosuccinate Lyase (Argininosuccinic Aciduria)
- Argininosuccinate Synthetase (Citrullinemia)
- Aryl Sulfatase A (Metachromatic Leukodystrophy)
- Aryl Sulfatase B (Maroteaux-Lamy Mucopolysaccharidosis)
- Aspartylglucosaminase (Aspartylglucosaminuria)
- Biotinidase
- Carbamyl Phosphate Synthetase (CPS Deficiency)
- Alpha-Fucosidase (Fucosidosis)
- Galactocerebrosidase-Beta-galactosidase (Krabbe Disease)
- Galactose-1-PO₄ Uridyl Transferase (Galactosemia)
- Alpha-Galactosidase (Fabry Disease)
- Beta-Galactosidase (GM1 Gangliosidosis)
- Alpha-Glucosidase (Pompe Disease)
- Beta-Glucosidase (Gaucher Disease)
- Beta-Glucuronidase (Glucuronidase Deficiency MPS)
- Hexosaminidase A & B (Tay-Sachs Disease)
- Hypoxanthine Phosphoribosyl Transferase (Lesch-Nyhan Disease)
- Alpha-L-Iduronidase (Hurler & Scheie Mucopolysaccharidosis)
- Alpha-Mannosidase (Mannosidosis)
- Nucleoside Phosphorylase (PNP Deficiency)
- Ornithine Transcarbamylase (OTC Deficiency)
- Phosphatidylinositol -4,5-P₂-5-Phosphatase (Lowe Syndrome)
- Sialidase (Sialidosis)
- Sphingomyelinase (Niemann-Pick Disease)
- Steroid Sulfatase (X-Linked Ichthyosis)

PLEASE CONSULT THE LABORATORY PRIOR TO SUBMITTING SKIN FIBROBLAST CULTURES OR PRENATAL DIAGNOSES BY ENZYME ANALYSES.