# Genetic Testing Laboratory Request Form

Group Health Cooperative of South Central Wisconsin

Please carefully complete this entire form and fax to **GHC-SCW *Care Management* FAX: 608-831-6099**
Please print clearly.

**DATE:_____**

**PATIENT INFORMATION**
Patient name:_____GHC or UW #:_____
Patient DOB: _____

**PROVIDER INFORMATION**
Name of ordering provider and clinic:_____
Name of genetic counselor/office contact:_____
Phone: (  )_____ Fax: (  )_____

**GENETIC TEST INFORMATION**
Name of test:_____ICD 10-Diagnosis code(s):_____
Do you have a preferred clinical laboratory for genetic testing?
__NO, GHC-SCW may choose the testing laboratory (skip to "CLINICAL DOCUMENTATION" section)
__*YES, preferred lab:_____

Is there a reason why testing should/must be performed at this laboratory or would other laboratories also be acceptable? Please explain:_____
_____
_____
List price (for above test) from preferred testing laboratory:_____
CPT codes (for above test) from preferred testing laboratory:_____
_____
*Please complete requisition forms (*with MD signature*) and send a copy with this request.
Please note that GHC-SCW staff will complete billing information on requisition forms.

**CLINICAL DOCUMENTATION--Please outline the reason for genetic testing and how this will affect medical management*. (Please check one of the following)**
___Clinical documentation is attached with this request.
___Clinical documentation (appt date :_____) has already been sent to a GHC-SCW provider.
*Please note that we will not process requests prior to obtaining the above documentation.

**INFORMED CONSENT (please check one of the following)**
___Yes, we have obtained informed consent and a signed patient consent form is attached.
___Yes, we have obtained informed consent but a patient consent form will need to be signed at the time of the blood draw/specimen collection.
___*No, the patient has not given informed consent. *If this option is selected, we will arrange for the patient to have genetic counseling at GHC-SCW to obtain informed consent prior to testing.

**URGENT TEST:** yes/no (circle one). If yes, indicate reason:_____

**MULTIPLE LAB ORDERS**
If multiple genetic labs are requested for a GHC-SCW member, please fill out a separate form for each test requested and indicate the appropriate order of testing.

Please contact the GHC-SCW Genetics Coordinator with any questions:
Melissa Baraboo, MS, CGC at (608) 661-7200 or mbaraboo@ghcscw.com

Revised 10/24/18