For Hospital Registration Label	**ADD-ON TESTS** **CYTOGENETICS TEST REQUEST FORM** The University Hospital of Arkansas CYTOGENETICS LABORATORY 5800 West 10th, Ste. 200, Slot 834 Little Rock, AR 72204 Ph 526-8000, FAX 526-7468

Ordered By: Dr. ____Pager:____________________

Original Specimen Collection Date: ____

Time & Date of ADD-ON Request: ____

Diagnosis: ____

Location: ____Phone:______________________

Requestor: ____Phone:______________________

In order for the Laboratory and the test requestor to comply with Medicare and CLIA regulations regarding test ordering and record retention, this form must be complete to be valid. Incomplete forms will be rejected and testing not performed. Please use this form for adding tests to previously submitted lab samples.

Please use this form when submitting requests for add-on Cytogenetic tests. Medicare provides reimbursement for tests that are medically necessary for the diagnosis or treatment of the patient on whom tests are ordered. The Office of Inspector General (OIG) takes the position that physicians who knowingly order medically unnecessary tests for which Medicare reimbursement is claimed may be subject to civil, criminal, and administrative penalties and sanctions.

PLEASE PRINT TEST(S) TO BE ADDED HERE

FOR LAB USE ONLY
___________Test to be performed. ____________Test unable to be performed. Reason for rejection: _____ Sample too old. _____ Sample QNS. ______ Unable to locate sample.