Shodair
CHILDREN'S HOSPITAL

Department of Medical Genetics
• Clinical Genetics • Cytogenics • Maternal Serum Screening
• Molecular Genetics • Newborn Screening Follow Up • Pharmacogenetics

Clinic 406.444.7530 Clinic Fax 406.444.1064 Laboratory 406.444.7532 Lab Fax 406.444.1022

www.shodair.org | 800.447.6614 | P.O. Box 5539 | 2755 Colonial Drive | Helena, MT 59601

MEMO FROM GENETIC LABORATORY

TO: Health Care Provider
FROM: Department of Medical Genetics at Shodair Children's Hospital
RE: Fetal Pathology Specimens

Enclosed please find forms regarding shipment of the fetal loss specimen or products of conception to our laboratory for genetic studies and/or external fetal exam.

Take into consideration that if at the time of specimen collection the patient is "admitted" at your site, Shodair will bill the referring facility.

- Please be aware that we need to have the form "Authorization for Fetal Studies and Dispatch" reviewed and signed by the patient. We would like this enclosed with the specimen, however it may be FAXed to (406)444-1022 if enclosure with specimen is not practical. We will not be able to process the specimen for any studies without this signed form.

- It is especially important to let your patients know that, in many circumstances, the cost of the fetal exam and genetic laboratory studies may not be a covered expense by their insurance provider, including Medicaid. It is recommended that the insurance provider be contacted before submitting the specimen. Patients are responsible for any charge not covered by insurance.

- A genetic counselor is available to speak with your patient about this loss. Someone can be reached at 1-800-447-6614 during normal business hours.

- If you have further questions please contact us at (406)444-7532. Please leave a voice mail with contact information if you are calling after hours.

Please fill the forms in the last three pages (page 6, 7 and 8) in this package and send the forms with the specimen!

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An explanation of the different options:

Limited Fetal Pathology (external exam): An external exam of the body and placenta to identify any physical abnormalities or birth defects that might explain the cause for the demise.

Cytogenetics: A sample of tissue is taken to culture cells for study. This looks at the structure of the fetal chromosomes to identify any obvious structural defects or missing or extra chromosomes as you would see for example in Down syndrome.

Limited Fetal Pathology (external exam) and cytogenetics: After the external exam, a geneticist confers with the ordering physician to discuss whether to continue with chromosome studies. * If the family is unsure which options they want, this is the best one to choose as chromosome studies can always be cancelled. There is a setup fee of $150 that is charged if the studies are started and cancelled.*

Please use FedEx overnight shipping services, and check the option of "Saturday delivery" if specimens are ready to send out on Friday. On the weekends we do have lab staff on site. You can either call 406-444-7532 and leave a message which they will return, or call 1-800-447-6614 which will connect you with one of our inpatient units. Ask for the genetics laboratory and they will get a message to them.

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Instructions for shipping

Before Dispatch, Please Call Shodair Genetics Lab at
406-444-7532 or 1-800-447-6614 (Ask for The Cytogenetics Laboratory)

Chromosome and DNA Studies

General:

- May be on any tissue, but typically the samples are: *Blood, Bone Marrow, or Fetal Tissue Biopsies.*
- Method of shipment should be over night by FedEx. Please check the option "Saturday Delivery" for specimen sent out on Friday.
- Order form/referral sheet should be filled out completely and included for each specimen.
- Call Shodair with any questions before 5pm:
- **1-800-447-6614, ext 7532.**
- **Weekends and after 5pm: 406-444-7532 (voicemail after hours)**

Details of packaging and shipping:

- Specimen containers must be marked with the patient name and a second unique identifier such as referring lab number or date of birth. Be sure that paperwork is included with the specimens.
- Enclose specimens in biosafety-approved packaging. Packaging should be leak-proof and the paperwork protected from specimen. BIOHAZARD LABELS ON THE INSIDE BOX ONLY.
- Send specimen as soon as possible by preferred carrier (**FedEx** or other professional couriers). Sample should arrive no later than the day following collection.
- Label with our address and designate:
- **URGENT – KEEP AT ROOM TEMPERATURE**

Fetal Pathology Specimens

General:

- Send the whole **UNFIXED/UNFROZEN** specimen (fetus and placenta). If tissue sampling is done onsite, label with tissue type. Place specimen in sterile container with proper transport media.
- If the specimen (gestation less than 20 weeks or weighing less than 500g) is small, place in a sterile plastic urine jar.
- If specimen is large, place placenta in a sterile sealable plastic container and tape to seal. Double bag fetus and place in Styrofoam or plastic container laying flat. Use bags to pack the fetus securely in the container for transit.
- Insulate with absorbent material and place in appropriately sized cardboard box for shipping with completed paperwork, protected from leakage.
- Mark the outer box with "fragile" and "do not freeze." Do **NOT** mark outer box with "biohazard." Send specimen as soon as possible by preferred carrier (**FedEx** or other professional couriers).
- **Before dispatch, please call Shodair at 1-800-447-6614, ext 7532.**

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Packaging of POC Laboratory Specimens for Send Out

POC of fetal Demise (must be fresh tissue, non-fixed, non-frozen)

1. Transport tissue biopsies in sterile saline with no preservatives, viral transport media or tissue culture media.
2. Place smaller specimens in tube or submit original container, label tube or container with patient information and biohazard sticker.
3. Place tube in biohazard bag.
4. Place tube in 2nd plastic non-sterile container, line with absorbent materials and label with biohazard sticker.
5. Tape container securely.
6. Enclose completed request form in biohazard bag paperwork slot.
7. Place in Styrofoam box with cold packs if necessary.
8. Place in cardboard box.
9. Make sure that Delivery Service knows that it is a Clinical Laboratory Specimen to ensure proper transportation.
10. Do not place biohazard warning stickers on outside of boxes.
11. Call **(406)444-7532** to review shipment of sample and get further instructions if needed.

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FETAL PATHOLOGY SERVICES

PROTOCOL FOR SENDING PRODUCTS OF CONCEPTION AND ABORTUSES

I. Discuss appropriateness of genetic referral with the parents.

II. Decide if fetal pathology, chromosome study or both are indicated. Refer to a current price list, if appropriate, for this decision.

III. Send the **WHOLE UNFIXED / UNFROZEN** specimen including **FETUS AND PLACENTA**. See Shipping Instructions for details.

For fetal material of less than 20 weeks gestation or less than 500 grams, the following documents must accompany the specimen:

- ☐ **1.** Shodair form "Authorization for Fetal Studies and Dispatch" SIGNED BY PARENT(S); COPY GIVEN TO PARENTS. This form is available from the Shodair Genetics Laboratory, or copy the example in this catalog.
- ☐ **2.** Shodair Fetal Studies Request Form. This form is available from the Shodair Genetics Laboratory, or copy the example in this catalog.
- ☐ **3.** Any relevant OB records, medical summary, ultrasound report, etc.

For fetal material of age 20 weeks gestation or more the following documents in addition to those listed above must accompany the specimen:

- ☐ **4.** The MONTANA DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES, AUTHORIZATION FOR REMOVAL, TRANSPORTATION AND FINAL DISPOSITION OF A DEAD BODY form. It is available through your hospital, and required by Montana law. The upper portion of this form should be filled in and the bottom line signed by physician, physician's designee, coroner or mortician authorizing body removal from the place of death. (This document is not necessary if sampling is done onsite and only a piece of fetal material is sent to Shodair for cytogenetic studies.)
- ☐ **5.** Wrap specimen in absorbent material and place in a strong, leak-proof and insulated container (preferably two such containers, one inside the other). Cold packs may be enclosed with larger specimens, but no ice.
- ☐ **6.** Mark Biohazard on inside box only.

Send immediately to the Shodair Genetics Laboratory via FedEx overnight delivery. **CALL THE LABORATORY AT SHODAIR HOSPITAL WHEN YOU ARE SENDING THE SPECIMEN OR IF YOU HAVE QUESTIONS: 406-444-7532; 1-800-447-6614.**

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CHILDREN'S HOSPITAL

SHODAIR CHILDREN'S HOSPITAL GENETICS LABORATORY
2755 Colonial Dr, Helena. MT, 59601 (406) 444-7532 (800) 447-6614
Fax (406) 444-1022, Email: mtgene@shodair.org

SHODAIR LAB #:

FETAL STUDIES REQUEST FORM *(Please send this completed form with the specimen)*

MOTHER: LAST NAME _____ **FIRST NAME** _____ **DOB** _____

FATHER: LAST NAME _____ **FIRST NAME** _____ **DOB** _____

Fetus Gender M / F **DATE & TIME OF DELIVERY:** _____ **Optional: Fetus Name:** _____

REF. LAB #: _____ **DATE COLLECTED:** _____ **DATE RECEIVED:** _____

ETHNIC BACKGROUND: (Circle all that apply) European Caucasian, Hispanic, Native American, African American, Asian, Other

REFERRING PHYSICIAN/ HEALTH PROFESSIONAL:
Name: _____
Address: _____
City, State, Zip: _____
Telephone:(____)_____FAX:(____)_____

PRIMARY CARE PHYSICIAN: _____
REFERRING INSTITUTION / CLINIC / LABORATORY:
Name: _____
ADDITIONAL REPORTS TO:
Name: _____

PHYSICIAN SIGNATURE:
(required for Medicare / Medicaid billing) **Date:**

BILLING INFORMATION:
☐ **REFERRING INSTITUTION**

New clients please call laboratory with financial contact information.

☐ **INSURANCE**
Name of policy holder: _____
Policy holder DOB: _____
SS # (Guarantor): _____
Address: _____
Phone #: _____
Relationship to patient: _____
Insurance Co. / Policy #: _____
Insurance Co Contact / Phone #: _____

☐ **Medicaid #:** _____
State (MT, ID WY): _____
SS#: _____

☐ **SELF PAY**

☐ **Inpatient**

CLINICAL INFORMATION

GRAVIDA:_____ **PARA:**_____ **Spontaneous Abortions:**_____ **Therapeutic Abortions:**_____ **MOLAR: Yes**___ **No**___ **Stillbirths:**___

PRESENT PREGNANCY **LMP:** _____ **Pregnancy weeks by U/S:** _____ **Date of U/S:** _____

FAMILY HISTORY	YES	NO	SPECIFY
Repeated miscarriages	____	____	_____
Stillbirth	____	____	_____
Malformed	____	____	_____
Mental retardation	____	____	_____
Other	____	____	_____

MATERNAL SERLOGICAL ESTS:

	POSITIVE	NEGATIVE	TITER/SPECIFY
Toxoplasmosis	____	____	_____
Syphilis	____	____	_____
Rubella	____	____	_____
CMV	____	____	_____
Herpes	____	____	_____
Coombs	____	____	_____
Others (Specify)	____	____	_____

PRESENT PREGNANCY	YES	NO	SPECIFY
Threatened abortion	____	____	_____
Oligo/polyhydramnios	____	____	_____
Diabetes	____	____	_____
Pre-eclampsia/eclampsia	____	____	_____
Hypertension	____	____	_____
Alcohol	____	____	_____
Drugs	____	____	_____
Cigarettes	____	____	_____
X-rays	____	____	_____
Other exposures	____	____	_____
Prenatal diagnosis	____	____	_____
Illnesses/operations	____	____	_____
Consanguinity	____	____	_____
At risk serum screen	____	____	_____

Other: _____

SPECIMEN TYPE: (Please circle) PLEASE NOTIFY THE LABORATORY WHEN A SPECIMEN IS BEING SENT. 1-800-447-6614, EXT. 7532

☐ **Fresh tissue:** ☐ **POC** ☐ **fetal** ☐ **other (specify source):** _____

TEST REQUESTED: (Please check one or more; test descriptions with CPT codes and prices faxed on request).

☐ **Limited Fetal Pathology (external exam)** ☐ **Cytogenetics** ☐ **Other:** _____

Date Set Up: _____ **Med. Rec. #** _____ **Admit #** _____ **Shire #** _____

PLEASE CALL LAB @ (406)444-7532 WITH SHIPPING DETAILS.

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Authorization for Fetal Studies and Dispatch

(Please send this completed form with the specimen)

To be filled out for all specimens regardless of gestational age.

We (I),_____ the parent(s) of _____, delivery date_____, hereby permit release to the Department of Medical Genetics at Shodair Children's Hospital, Helena, MT, for limited fetal pathology studies (external exam, no removal of organs) and chromosome studies as indicated below:

Check from the following:

PROCEDURE	COST OF SERVICE: Approximate price range by gestational age* <20 weeks &≥ 20 weeks
❑ Limited Fetal Pathology (external exam)	$241
❑ Cytogenetic studies only	$887
❑ Limited Fetal Pathology (external exam) and Cytogenetics	$1,128
❑ Molecular (DNA) studies if required	*Please inquire*

Further, I authorize: (Check only one box)

❑ The return of the remains to_____(mortuary) or _____Hospital Laboratory

❑ Shodair Children's Hospital to dispose of the remains. (applies only to <20 weeks gestation)

❑ Cremation and return of ashes to: (May apply to any gestational age)_____ _____

❑ Cremation without return of ashes. (Applies only to ≥ 20 weeks gestation)

Please Note: There is a $75.00 (<20 weeks) or $100.00 (≥ 20 weeks) charge for cremation of fetal material.

* A detailed price list is available.

I understand that I should contact my insurance provider (including Medicaid) for coverage of these services and that I am financially responsible for charges not covered by insurance.

_____
Mother's signature

_____
Father's signature

_____
Witness

_____
Witness

A genetic counselor is available to speak with you about your loss and answer questions about laboratory services. Please contact the Medical Genetics Department at Shodair Children's Hospital by calling toll-free 1-800-447-6614. (This form may be photocopied).

Please send this completed form with the specimen for fetal material of age ≥ 20 weeks

MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

Vital Statistics Bureau
PO Box 4210, Helena, MT 59604-4210

AUTHORIZATION

FOR REMOVAL, TRANSPORTATION AND FINAL DISPOSITION OF A DEAD BODY

☐ ORIGINAL TO Local Registrar ☐ ONE COPY TO Coroner ☐ ONE COPY TO MORTUARY/PERSON IN CHARGE OF DISPOSITION ☐ ONE COPY TO CEMETERY/CREMATORY OR TO ACCOMPANY REMAINS OUT-OF STATE

Machine or Facsimile copies of this form shall be valid for all purposes

DECEDENT

If fetal death, check this box: ☐ and provide data for mother or fetus as appropriate

NAME: _____ DATE OF BIRTH: _____

SOCIAL SECURITY NUMBER: _____ ☐ Male ☐ Female

DIED (or was found) ON: _____
date and time

AT: _____
name of institution, address, location of death or discovery as best described, including city or town

_____

IN _____ COUNTY.

AUTHORIZATION

TO BE COMPLETED BY INDIVIDUAL AUTHORIZING REMOVAL, TRANSPORTATION AND FINAL DISPOSITION:

I HEREBY AUTHORIZE THE REMOVAL, TRANSPORTATION AND FINAL DISPOSITION OF THE REMAINS OF THE ABOVE-NAMED DECEDENT (OR IDENTIFIED FETUS) PURSUANT TO MY AUTHORITY UNDER 50-15-405 M.C.A.

I CERTIFY THAT I AM:

☐ **THE CORONER HAVING JURISDICTION** ☐ **A MORTICIAN LICENSED UNDER 37-19-302, M.C.A.**
☐ **THE PHYSICIAN IN ATTENDANCE AT DEATH or THE PHYSICIAN'S DESIGNEE**

signature | **date** | **Montana license # (*if any*)**

name (*typed or printed*) | **name of agency or firm represented (*if applicable*)**

address | **city** | **state** | **zip**

If authorization is by person other than a mortician licensed under 37-19-302, M.C.A.
name and address of mortuary/person *in charge of disposition* and filing of death certificate under 50-15-403, M.C.A.

name (*typed or printed*) | **firm (if applicable)**

address | **city** | **state** | **zip**

DISPOSITION

Cremation Authorization: _____ _____
coroner's signature **date signed**

CEMETERY OR CREMATORY AUTHORITY MAY COMPLETE

date of disposition | cemetery or crematory name | ☐ buried ☐ cremated

city of disposition | county | state | sexton or person in charge