



Cytogenetics and Genomics Request

FOR CYTOGENETICS USE ONLY

1. Specimen Type *

Prenatal

- Amniotic Fluid
 Chorionic Villi
 Cord Blood
 Products of Conception
 Tissue-fetal:
 Fetal Sex: Male Female
 Site: _____

(Please complete for prenatal specimens)

Gestational age: _____
 By dates: _____
 By ultrasound: _____

Postnatal

- Blood in Heparin in EDTA for (PCR or array CGH)
 Skin biopsy: Cord blood
 Site: _____

Neoplasia

- Bone Marrow Paraffin Block/Slides
 Bone Core Biopsy Urine
 Blood Other: _____

* Indicates required fields

2. Tests Ordered *

Karyotype

- Routine Analysis Family Follow-up Reflex to array CGH if karyotype normal (see array requirements)
 Mosaicism for: _____

FISH

- Please see website or supplemental FISH form for a complete list of probes.
 FISH for: _____
 Prenatal FISH for aneuploidy Urine IFISH testing

Array CGH (oligo based)

- Routine Follow-up
 Other: _____

Other

- Y-PCR for Male Infertility Breakage Study (control required)
 Other: _____
 STAT: _____

3. Clinical Diagnosis/Indications

Diagnosis: *

Clinical history:

Rule out:

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4. Patient Information

Date sample obtained: *	Patient name: *	Patient number:	
Age: *	DOB: *	SSN #:	Sex: * <input type="checkbox"/> Male <input type="checkbox"/> Female

5. Physician Information

Requesting Physician name: * (Print Clearly)	UPIN/Staff #/NPI/EPIC ID *	
Hospital or Clinic: *	Sender phone #: *	Physician phone #: *

Bill to: * Referring Hospital
 Patient Insurance (You must provide patient address, SSN #, phone # and insurance information)
 See website for patient billing information

SHIPPING INSTRUCTIONS

Please call (206) 598-4488 before shipping
 Keep samples at room temperature, except refrigerate Autopsies/Abortus/Tumors/Urine
 Seal well, label and bag tubes/containers
 Send via cab or overnight express carrier