PATIENT NAME: ______________________
LAST FIRST

Address/Phone:

Sex: ☐ M ☐ F Date of Birth: ____/____/____

ORDERED BY:

COLLECTED BY:

DATE TIME AM PM

UPSTATE
UNIVERSITY HOSPITAL

Cytogenetics Laboratory

Clinical Pathology - 3733 UH
750 East Adams Street
Syracuse, NY 13210
(315) 464-4716 Fax: (315) 464-4718

Medical Record #

DIAGNOSIS/ **ICD Code(s) REQUIRED:**

As the referring physician, I certify that the tests ordered below are medically necessary for the diagnosis or treatment of this patient. I hereby attest to the fact that I have provided the patient or patient's guardian with the information contained in the NYS Civil Rights Act, Section 79-l, and have obtained written informed consent as required.

Requesting Physician (print): ______________________

Physician Signature: ______________________

Address: ______________________

Phone: ______________ Fax: ______________

For Lab Use Only:

Lab No: ______________

Date Received: ____/____/____

Time Received: ______________

Previous Cases: ______________

CYTOGENETIC TESTING: All tests include cell culture. Additional cell counts and or special staining procedures may be required to complete the requested study. **INFORMED CONSENT (form F82875) REQUIRED** for inherited or *de novo* constitutional disorders.

PERIPHERAL BLOOD:

DIAGNOSIS/CLINICAL INFORMATION:

TEST REQUESTED:

- ☐ Karyotype Analysis - Standard Karyotype
- ☐ High Resolution Karyotype - **DIAGNOSIS REQUIRED**
- ☐ FISH: Probe(s) requested ______________
- ☐ Microarray Testing: Informed Consent (Form F88925) and Medical Necessity (Form F91005) **REQUIRED**

AMNIOTIC FLUID

TEST REQUESTED:

- ☐ Karyotype Analysis
  - Date of tap ____/____/____
  - Gestational age: by dates ________ by ultrasound ________
  - Gravida ________ para ________ Living children ________
  - SAB ________ Multiple pregnancy ________
- ☐ FISH (fluorescence in situ hybridization) **DIAGNOSIS REQUIRED**
  - ☐ AneuVysion (CHR. 13, 18, 21, X, Y)
  - ☐ Metaphase FISH: probe(s) requested ______________

DIAGNOSIS/CLINICAL INFORMATION:

Indication for Test:

- ☐ Advanced Maternal Age
- ☐ Abnormal MSAFP ________ Low ________ High ________ Value
- ☐ Abnormality on ultrasound (describe ABOVE)
- ☐ Previous child with chromosome abnormality (describe)
- ☐ Parent with structural chromosome abnormality (describe)
- ☐ Other - describe

TISSUE:

Type of Tissue: ______________

TEST REQUESTED:

- ☐ Karyotype Analysis
- ☐ Cell culture for send out or freezing/storage
- ☐ Other: ______________

DIAGNOSIS/CLINICAL INFORMATION:

Gestational age: ______________

Tissue biopsy location:
- ☐ Skin - Fetal
- ☐ Placenta
- ☐ Products of conception
- ☐ Other: ______________

SPECIMEN REQUIREMENTS:

Peripheral Blood: Green (sodium heparin) vacutainer tube. Adults: 3-5 mL, Infants and children: 2-3 mL. Transport and store at room temperature. Blood for high resolution analysis should be received on a Monday or Tuesday for optimum results.

Amniotic Fluid: Collect 15-20 mL of amniotic fluid in sterile, labeled tubes, maintain at room temperature, and deliver to the Cytogenetics Laboratory within 24 hours of collection. The first few mLs of fluid are most likely to contain maternal cells and should **NOT** be submitted.

Tissue: Skin or solid tissue obtained by sterile biopsy should be placed in sterile medium (Ham's F-10, Dulbecco's MEM, RPMI 1640, isotonic saline). Do **NOT** place in hypotonic saline. Place on wet ice and transport to the Cytogenetics Laboratory **ASAP**. Sterile medium is available on request from the Lab.