

THIS IS NOT A TEST REQUEST FORM.
The information below is required to perform cytogenetic (chromosome) studies.
Please fill out this form and submit with the test request form or electronic packing list.

PATIENT HISTORY FOR CYTOGENETIC (CHROMOSOME) STUDIES

Patient's Name _____ Date of Birth ____/____/____ Gender F Male
 Physician _____ Physician Phone (____) _____ Practice Specialty _____
 Genetic Counselor _____ Counselor Phone (____) _____

PEDIATRIC/ADULT CONSTITUTIONAL STUDIES

Indication for testing (check all that apply - required):

- Cardiac defect (specify) _____
- Multiple congenital anomalies
- Intellectual and/or developmental disability
- Autism/PDD
- Learning disabilities
- Dysmorphic features
- Genital anomalies
- Ambiguous genitalia
- Infertility
- Recurrent miscarriage
- Partner with recurrent miscarriage
(Partner's Name) _____
- Familial translocation/inversion (specify) _____
- Previous child with chromosome abnormality (specify) _____
- Other (specify) _____

Sample Type:

- Whole blood
- Cord blood (newborn or stillborn infant)
- Skin Biopsy

Study Type:

- Chromosome analysis (karyotype)
- Genomic microarray (aCGH)
- Chromosomes with reflex to microarray
- Newborn FISH panel (13, 18, 21, X, Y)
- Newborn FISH panel w/reflex to microarray if normal
- FISH for specific condition: (specify) _____
- Family study
Name of relative with identified cytogenetic abnormality _____
Relationship to patient? _____
What was their result? (Attach report) _____

ONCOLOGY STUDIES

Diagnosis: _____

WBC: _____ % Blasts: _____

Has the patient had a bone marrow transplant?
If yes, what was the sex of the donor?

- Yes No
- Male Female

Has the patient had previous radiation or chemotherapy?

- Yes No

Sample Type:

- Whole Blood
- Bone Marrow
- Bodily Fluid – specify source _____
- Solid Tumor – specify source _____

Study Type:

- Lymphoid Disorder
- Myeloid Disorder
- FISH –specify probe(s) and/or condition _____

Master Label