

PATIENT NAME: _____ LAST FIRST		ORDERED BY: _____	<h1 style="text-align: center;">UPSTATE</h1> <p style="text-align: center;">UNIVERSITY HOSPITAL</p> <h2 style="text-align: center;">Cytogenetics Laboratory</h2> <p style="text-align: center;">Clinical Pathology - 3733 UH 750 East Adams Street Syracuse, NY 13210 (315) 464-4716 Fax: (315) 464-4718</p>
Address/Phone: _____		COLLECTED BY: _____	
Sex: <input type="checkbox"/> M <input type="checkbox"/> F Date of Birth: ____/____/____		DATE TIME AM PM	
Medical Record # _____	DIAGNOSIS/ ICD-9 Code 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.	For Lab Use Only: Lab No: _____ Date Received: ____/____/____ Time Received: _____ Previous Cases: _____
Requesting Physician (print): _____	
Physician Signature: _____	
Address: _____	
Phone: _____ FAX: _____	

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.

INDICATIONS FOR TESTING:

DIAGNOSIS: _____

CLINICAL FINDINGS and/or REASON FOR TESTING:

SPECIMEN TYPE: <input type="checkbox"/> Peripheral Blood <input type="checkbox"/> Bone Marrow WBC: _____ <input type="checkbox"/> Leukemic Blood WBC: _____ <input type="checkbox"/> Cord Blood/PUBS <input type="checkbox"/> Other: Specify _____	TEST REQUESTED: (SELECT ONLY ONE OF THE FOLLOWING) <input type="checkbox"/> Karyotype Only – Standard Analysis <input type="checkbox"/> High Resolution Karyotype Analysis (peripheral blood only) DIAGNOSIS REQUIRED <input type="checkbox"/> FISH (fluorescence in situ hybridization) plus Standard Karyotype DIAGNOSIS REQUIRED <input type="checkbox"/> FISH plus 5 Cell Karyotype (if full karyotype is not needed) DIAGNOSIS REQUIRED <input type="checkbox"/> FISH Follow-up Study DIAGNOSIS REQUIRED
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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.
Bone Marrow: Submit 1-2 ml of the **FIRST** aspirate in a green (sodium heparin) vacutainer tube. Transport at room temperature and deliver to the Cytogenetics Lab ASAP after collection.