

**Cytogenetics Laboratory**

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

PATIENT NAME: \_\_\_\_\_  
 LAST FIRST  
 Address/Phone: \_\_\_\_\_  
 \_\_\_\_\_  
 Sex:  M  F Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

ORDERED BY: \_\_\_\_\_  
 COLLECTED BY: \_\_\_\_\_  
 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: \_\_\_\_\_

**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 REQUIRED for inherited or de novo constitutional disorders.**

**INDICATIONS FOR TESTING:**  
 DIAGNOSIS: \_\_\_\_\_

CLINICAL FINDINGS and/or REASON FOR TESTING:

**SPECIMEN TYPE:**

Peripheral Blood  
 Bone Marrow WBC: \_\_\_\_\_  
 Leukemic Blood WBC: \_\_\_\_\_  
 Cord Blood/PUBS  
 Other: Specify \_\_\_\_\_

**TEST REQUESTED**

Karyotype Only – Standard Analysis  
 High Resolution Karyotype Analysis **DIAGNOSIS REQUIRED**  
 FISH (fluorescence in situ hybridization) **plus** Standard Karyotype **DIAGNOSIS REQUIRED**  
 FISH **plus** 5 Cell Karyotype (if full karyotype is not needed) **DIAGNOSIS REQUIRED**  
 FISH Follow-up Study **DIAGNOSIS REQUIRED**

**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.

### Patient Informed Consent

The New York State Civil Rights Act, Section 79-l requires that all individuals be informed of the nature of the genetic testing being requested. The following points must be covered in this discussion.

- 1. What is karyotype analysis?** Karyotype analysis is the study of the chromosomes that are present in human cells. The chromosomes are structures on which the genes are located. Genes encode the hereditary material that provides the blueprint for an individual.
- 2. What is the purpose of karyotype analysis and what are its limitations?** This test will allow an examination of the chromosomes to determine if there is any change in chromosome number or structure that might be associated with the patient's clinical history or clinical abnormalities. Occasionally, a structural defect may not be detected because it is too small to be seen visually.
- 3. What is fluorescence in situ hybridization (FISH)?** FISH combines cytogenetics and molecular diagnostics to provide more detailed and specific information regarding cytogenetic abnormalities that may aid in confirmation of a diagnosis.
- 4. What is the purpose FISH and what are its limitations?** FISH can provide additional clinical information on chromosome anomalies that are too small to be detected by standard cytogenetic analysis. It is particularly powerful in identifying microdeletions and the presence of extra or missing chromosomes. This test is greater than 97% accurate in appropriate applications, but, since some disorders may have more than one cause, FISH may not provide a definitive diagnosis.
- 5. What will happen to the cells once the test is complete?** No tests other than those authorized will be performed. The cells may be stored for up to 10 years.
- 6. How will I obtain results from the test?** The test result will be provided to your physician who will discuss it with you.

If you have any questions about the test which will be performed, you may contact the Cytogenetics Laboratory at 315 464-4716. You may also wish to obtain genetic counseling prior to signing this form.

My signature below indicates that the above information has been explained to me and that I give consent for :

Karyotype analysis and/or  FISH analysis (check one or both).

Please indicate the name and address of physicians **other** than the referring physician to whom you wish a copy of the report to be sent:

\_\_\_\_\_  
Physician's name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone number

\_\_\_\_\_  
Date

\_\_\_\_\_  
**Signature of Patient**  
or Parent/Guardian if patient is a minor

\_\_\_\_\_  
Patient's name (**printed**)