PATIENT NAME: _____
LAST FIRST

Address/Phone:

_____

_____

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

ORDERED BY:

COLLECTED BY:

DATE TIME AM PM

Medical Record #

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

UPSTATE
UNIVERSITY HOSPITAL

Cytogenetics Laboratory

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

CONSTITUTIONAL STUDIES

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-I, 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:

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

AMNIOTIC FLUID

TEST REQUESTED:

- ☐ Chromosome 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:

- ☐ Chromosome Analysis - Standard Karyotype
- ☐ 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.