

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  
**CONSTITUTIONAL STUDIES**

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:**  
 Chromosome Analysis - Standard Karyotype  
 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  
 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.  
**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.