Cytogenetics Request Form

Sacred Heart Cytogenetics Laboratory
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PAML
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PATIENT NAME	SEX	DATE OF BIRTH (required)
FINANCIAL RESPONSIBLE PERSON	RELATIONSHIP TO PATIENT	
ADDRESS OF FINANCIALLY RESPONSIBLE PERSON		
INSURANCE	POLICY NO./ GROUP NO.	
REFERRING PHYSICIAN		
REFERRING HOSPITAL / LAB		
DATE SAMPLE DRAWN	TIME SAMPLE DRAWN	
CLINICAL INDICATION (SAMPLE CANNOT BE PROCESSED WITHOUT THIS)		

FAILURE TO COMPLETE REQUISITION WILL RESULT IN DELAYS

TEST REQUESTED

❑ CYTOGENETIC ANALYSIS: ❑ Routine Analysis ❑ High-Resolution ❑ Mosaicism ❑ Family Study

❑ FISH Probe(s) requested: ______________________________

❑ OTHER: ______________________________

TYPE OF SPECIMEN

❑ PERIPHERAL BLOOD ❑ SOLID TISSUE TYPES: ______________________________

❑ BONE MARROW ❑ OTHER: (Please describe) ______________________________

❑ AMNIOTIC FLUID ______________________________

COMPLETE FOR ALL AMNIOTIC FLUIDS AND POCs AS APPROPRIATE

GESTIONAL AGE (WKS LMP): ______

GESTIONAL AGE (BY ULTRASOUND): ______

G__________P_________SAB_________

AFP: ❑ YES ❑ NO

ACHE: ❑ YES ❑ NO

COMPLETE FOR ALL BONE MARROWS

PREVIOUS BONE MARROW ASPIRATIONS (DATE): ______

PREVIOUS CYTOGENETIC STUDIES (DATE): ______ CASE # IF KNOWN: ______

MEDICATION (PAST AND PRESENT): ______

RADIATION THERAPY: ______

CHEMOTHERAPY: ______