

**WARDE MEDICAL LABORATORY**  
**CYTOGENETICS TEST REQUISITION**  
734-214-0300 800-760-9969 Fax: 734-214-0399

**Patient Information**

Name: \_\_\_\_\_  
Last First MI

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: \_\_\_\_\_

Patient ID: \_\_\_\_\_ Specimen ID: \_\_\_\_\_

\*Referring Physician: \_\_\_\_\_ \* Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

\*Indication for Test: Clinical  
Information \_\_\_\_\_

**Chromosome Analysis/Array CGH**

- Chromosome Analysis, Constitutional (CHR): 10 mL Whole Blood Na Heparin  
 Reflex to Array CGH (Chromosome Microarray) if chromosome analysis is normal or does not produce optimal results.

Chromosome Analysis, Products of Conception (CHRPC): Tissue in Tissue Transport Medium (TTM)

Chromosome Analysis, Skin Biopsy (CHRPC): Tissue in Tissue Transport Medium (TTM)

Chromosome Microarray (CGH): 10 mL Whole Blood Na Heparin

**Fluorescence *in situ* hybridization (FISH)**

\*Specify Probes/Disorder: \_\_\_\_\_

FISH for Chromosome 21 (FISH)

POC FISH (Paraffin-Embedded Tissue) (FISH)

Permission granted to sacrifice block

Subtelomere FISH (FISH)

Specimen Type:  Peripheral blood  Paraffin-embedded tissue  Tissue (TTM)

Collection Date: \_\_\_\_\_ Time: \_\_\_\_\_

Additional Comments: \_\_\_\_\_

\* Required Fields

5/17/2016