

CYTOGENETICS TEST REQUISITION

Phone: 734-214-0300, 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