Warde
Medical Laboratory

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*: _____

NPI #:_____Fax: _____

Indication for Test*:

Clinical Information: _____

_____

Chromosome Analysis/Array CGH

- ☐ Chromosome Analysis, Constitutional (CHR): 10 mL Whole Blood Na Heparin (3.0 mL – Neonatal min)
  - ☐ 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 (3.0 mL – Neonatal min)
- ☐ **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

06/30/2025