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/Microarray

- ☐ Chromosome Analysis, Constitutional (CHR): 10 mL Whole Blood Na Heparin
  - ☐ Reflex to Chromosome Microarray (CGH) 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 Probe(s)/Disorder: ____

- ☐ FISH for Chromosome 21 (FISH)
- ☐ POC FISH (Paraffin-Embedded Tissue) (FISH)
  - ☐ Permission granted to sacrifice block
- ☐ Subtelomere FISH (FISH)

Specimen Type: ____

Collection Date: ________________ Time: ___________________

Additional Comments: ____

____

* Required Fields

7/15/2015