

PATIENT NAME: _____
 LAST FIRST
 Address/Phone: _____

 Sex: M F Date of Birth: ____/____/____

ORDERED BY: _____
 COLLECTED BY: _____
 DATE TIME AM PM _____

UPSTATE
 UNIVERSITY HOSPITAL
Cytogenetics Laboratory
 Clinical Pathology - 3733 UH
 750 East Adams Street
 Syracuse, NY 13210
 (315) 464-4716 Fax: (315) 464-4718

Medical Record # _____

DIAGNOSIS/ ICD-9 Code **REQUIRED:** _____

As the referring physician, I certify that the tests ordered below are medically necessary for the diagnosis or treatment of this patient. I hereby attest to the fact that I have provided the patient or patient's guardian with the information contained in the NYS Civil Rights Act, Section 79-l, and have obtained written informed consent as required.

For Lab Use Only:
 Lab No: _____
 Date Received: ____/____/____
 Time Received: _____
 Previous Cases: _____

Requesting Physician (print): _____
 Physician Signature: _____
 Address: _____
 Phone: _____

CYTOGENETIC TESTING: All tests include cell culture. Additional cell counts and or special staining procedures may be required to complete the requested study. **INFORMED CONSENT (form F82875) REQUIRED** for inherited or *de novo* constitutional disorders.

AMNIOTIC FLUID

TEST REQUESTED:
 Karyotype Analysis
 Date of tap ____/____/____
 Gestational age: by dates _____
 by ultrasound _____
 Gravida _____ para _____
 Living children _____
 SAB _____ Multiple pregnancy _____
 FISH (fluorescence in situ hybridization) **DIAGNOSIS REQUIRED**
 Aneuvysion (chr. 13, 18, 21, X, Y)
 Metaphase FISH: probe(s) requested _____

CLINICAL INFORMATION:

Indication for Test:
 Advanced Maternal Age
 Abnormal MSAFP _____ Low _____ High _____ Value
 Abnormality on ultrasound (describe below)
 Previous child with chromosome abnormality (describe)
 Parent with structural chromosome abnormality (describe)
 Anxiety
 Other - describe

TISSUE:

Type of Tissue _____
TEST REQUESTED:
 Karyotype Analysis
 FISH (fluorescence in situ hybridization) **DIAGNOSIS REQUIRED**
 Cell Culture only
 Cell freezing and storage
 Ship cells for additional studies

Diagnosis/Clinical Information:

Gestational age: _____
 Tissue biopsy location: Skin
 Placenta
 Products of conception
 Fetal cord
 Other:

SPECIMEN REQUIREMENTS:

Amniotic Fluid: Collect 15-20 ml of amniotic fluid in sterile, labeled tubes, maintain at room temperature, and deliver to the Cytogenetics Laboratory within 24 hours of collection. The first few mls of fluid are most likely to contain maternal cells and should **NOT** be submitted.
Tissue: Skin or solid tissue obtained by sterile biopsy should be placed in sterile medium (Ham's F-10, Dulbecco's MEM, RPMI 1640, isotonic saline). Do **NOT** place in hypotonic saline. Place on wet ice and transport to the Cytogenetics Laboratory ASAP. Sterile medium is available on request from the Lab.