CYTOGENETICS REQUEST

FOR CYTOGENETICS USE ONLY

Cytogenetics Laboratory, Room NW-125
University of Washington Medical Center BOX 356100
1959 N.E. Pacific Street
Seattle, Washington 98195-6100

PHONE: (206) 598-4488 FAX: (206) 598-2610
WEB: www.pathology.washington.edu/clinical/cytogenetics/

SHIPPING INSTRUCTIONS
- **Please call 206-598-4488 before shipping**
- **Keep samples at room temperature**

Except refrigerate Autopsy/Abortus/Tumors/Urine
- **Seal well, label and bag tubes/containers**
- **Send via cab or overnight express carrier**

1 SPECIMEN TYPE

Prenatal

(Please complete for prenatal specimens)
Gestational age:
By Dates:_____
By U/S:_____

- ☐ Amniotic fluid:
- ☐ Chorionic villi:
- ☐ Fetal umbilical blood:
- ☐ Products of conception:
- ☐ Tissue, fetal: Fetal sex: _____ Site:_____

Postnatal
- ☐ Blood: ☐ in heparin, ☐ in EDTA (PCR, Frag X, A-CGH)
- ☐ Skin, biopsy: Site_____

Neoplasia
- ☐ Bone marrow
- ☐ Bone core biopsy
- ☐ Blood - hematological disorder
- ☐ Paraffin Block/Slides
- ☐ Tumor
- ☐ Urine
- ☐ Other:_____

SPECIAL REQUESTS
- ☐ STAT
- ☐ Urgent preliminary requested, By date:_____
- ☐ High resolution analysis (for non-neoplastic blood)

2 TESTS ORDERED

(check all that apply)

Cytogenetics
- ☐ Karyotype (routine workup)
- ☐ Karyotype, family follow-up:
- ☐ Karyotype, mosaicism for:_____

FISH

Please see website or supplemental FISH form for a complete list of probes

- ☐ Neoplasia IFISH for:_____
  _____
- ☐ Prenatal IFISH for aneuploidy
- ☐ SKY (Spectral karyotyping)
- ☐ Telomere panel
- ☐ Urine IFISH testing
- ☐ FISH for _____

Other
- ☐ AFP (we will forward part to UWMC Lab. Medicine)
- ☐ Array CGH
- ☐ Breakage study (Control requested)
- ☐ Y PCR for male infertility
- ☐ Fragile X (we will forward EDTA blood to UWMC Genetics)
- ☐ Other:_____

3 CLINICAL DIAGNOSIS / INDICATION

DIAGNOSIS:

CLINICAL HISTORY:

RULE OUT:

FOR CYTOGENETICS USE ONLY

4 PATIENT AND REFERRAL INFORMATION

DATE SAMPLE OBTAINED ORD.STA.NO.

PT.NO.

NAME

AGE SEX

DOB SSN

PHYSICIAN'S SIGNATURE	UPIN/STAFF #
REQUESTING PHYSICIAN(S) PLEASE PRINT	*PHYSICIAN'S PHONE NO.*
SAMPLE SENT FROM: HOSPITAL / CLINIC	SENDER'S PHONE NO.

BILL TO:
- ☐ REFERRING HOSPITAL / CLINIC / PHYSICIAN
- ☐ PATIENT / INSURANCE: YOU MUST PROVIDE PATIENT ADDRESS, SSN, PHONE # AND INSURANCE INFORMATION (see website for patient billing form)