PITTSBURGH CYTOGENETICS LABORATORY

UPMC LIFECHANGINGMEDICINE

Constitutional Cytogenetic Study Requisition form

PATIENT INFORMATION (*Please Print):*	**REFERRING PHYSICIAN (*Please Print):***
Last Name: First: M.I.:	Name:
Address: Home Phone #:	Address:
City, State, Zip:	City, State, Zip:
Birthdate: _____ Sex: _____ Male _____ Female SS#(optional): _____	Telephone #:
Medical Record #: Account#:	Fax #:
Send Bill To: _____Insurance (please attach insurance info.) ____ Patient _____ Institution(list): _____	Additional Report To:

SPECIMEN INFORMATION:	**If PRENATAL SPECIMEN, Please Complete:**
Date/Time of Collection:	LMP: Grav. Para SA TA
Type of Specimen: **_____ Peripheral Blood _____ Cord Blood _____ Fetal Blood(PUBS)** **_____ Amniotic Fluid _____ CVS** **_____ Solid Tissue(list type of tissue): _____** **_____ Paraffin Section (list source): _____**	Ultrasound Date: **Gestational age:** Composite _____ BPD _____ **Ultrasound Abnormalities:** ____ Yes _____ No List: _____ _____ Is Patient a Diabetic? _____ Yes _____ No

INDICATION FOR STUDY: (*MUST BE COMPLETED!)*

____ Advanced Maternal Age
____ Increased Risk for ONTD by MSAFP Screening (Elev. AFP)
____ Increased Risk for Trisomy 18 by MSAFP Screening
____ Increased Risk for Down Syndrome by MSAFP Screening
____ Spontaneous Abortion/Stillbirth (Weeks Gestation: _____)
____ Hist. of Open Neural Tube Defects (*spina bifida, anencephaly)*
____ Ambiguous Genitalia -
- ? Previous Cytogenetic Analysis: ____XX ___ XY

____ Follow-up to prev. study (list test and date): _____

____ Developmental Delay ____ Intellectual disability
____ Congenital Heart Defect
____ Autism ____ Seizures ____ Encephalopathy
____ Multiple congenital anomalies
____ Repeated Pregnancy Losses ____ Infertility
____ Dysmorphic features (specify): _____
_____
____ Other: _____

TEST(S) REQUESTED: (*MUST BE COMPLETED!)*

____ Chromosome Analysis (Karyotype)
____ Amniotic Fluid AFP _____ Amniotic Fluid AchE
____ Fluorescence In Situ Hybridization (FISH) Studies:
_____ Prenatal Interphase Study (chroms. 13, 18, 21, X, Y)
_____ DiGeorge/VCF Syndrome (22q11)
_____ Prader-Willi Syndrome (15q11q13)
_____ Cri du chat Syndrome (5p-)
_____ Miller-Dieker Syndrome (17p13)
_____ Other(list): _____

____ R/O Duplication 15q11-q13
____ R/O Trisomy/Triploidy (Paraffin Section)
____ Williams Syndrome/elastin gene (7q11.23)
____ Angelman Syndrome (15q11q13)
____ Wolf-Hirschhorn Syndrome (4p-)
____ Smith-Magenis Syndrome (17p11.2)
____ R/O Trisomy(specify)_____

____ 180K SNP+CGH Combo Microarray Testing (Purple top tube required!)
____ 180K X-HR (X chromosome high resolution) Microarray Testing (Purple top tube required!)

Signature of Requesting Physician (REQUIRED!):

Lab Accession # Tech.: _____ Date Received:

Magee-Womens Hospital of UPMC
300 Halket St., Rm. 1225
(412)641-5558 PHONE (412)641-2255 FAX
Pittsburgh, PA 15213

1/31/2018 SJK