

SHODAIR LAB #:

LYMPHOCYTE AND OTHER TISSUE TEST REQUEST FORM FOR CHROMOSOME ANALYSIS (Cytogenetics, Karyotype)
 (Please send this completed form with the specimen)

PATIENT LAST NAME: _____ FIRST NAME : _____ DOB: _____
 SEX: M / F REF. LAB #: _____ DATE COLLECTED: _____ DATE RECEIVED: _____
 ETHNIC BACKGROUND: (Circle all that apply) European Caucasian, Hispanic, Native American, African American, Asian, Other

REFERRING PHYSICIAN/ HEALTH PROFESSIONAL: Name: _____ Address: _____ City, State, Zip: _____ Telephone:(____) _____ FAX:(____) _____	REFERRING INSTITUTION / CLINIC / LABORATORY: Name: _____ ADDITIONAL REPORTS TO: Name: _____
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PHYSICIAN SIGNATURE: _____ **Date:** _____
 (required for Medicare / Medicaid billing)

BILLING INFORMATION: <input type="checkbox"/> REFERRING INSTITUTION New clients please call laboratory with financial contact information.	<input type="checkbox"/> INSURANCE Name of policy holder: _____ Policy holder DOB: _____ SS # (Guarantor): _____ Address: _____ Phone #: _____ Relationship to patient: _____ Insurance Co. / Policy #: _____ Insurance Co Contact / Phone #: _____	<input type="checkbox"/> Medicaid #: _____ State (MT, WY, CO, UT): _____ SS#: _____ <input type="checkbox"/> SELF PAY <input type="checkbox"/> Inpatient
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INDICATION FOR ANALYSIS:
 Possible/Probable diagnosis: list symptoms ICD-9 Codes:

SPECIMEN TYPE: (Please check) PLEASE NOTIFY THE LABORATORY WHEN A SPECIMEN IS BEING SENT

Blood: SODIUM HEPARIN (green top tube-NOT lithium heparin) 5 to 10 ml, minimum 1 ml for infants, room temp **For DNA plus chromosome analysis, also submit 3 to 5 ml EDTA (purple top tube)**

Unfixed tissue, source: _____

Transport recommendations available, please contact the lab for further information.

TEST REQUESTED: (Please check one or more; test descriptions with CPT codes and prices faxed on request).

<input type="checkbox"/> Chromosomes (Karyotype) (CYTOGENETIC Studies) <input type="checkbox"/> Chromosomes + Direct FISH Interphase Aneuploidy for 13, 18, 21, X, Y (STAT Study) <input type="checkbox"/> Chromosomes + DNA Studies <input type="checkbox"/> FMR-1 screen <input type="checkbox"/> PWS/AS screen <input type="checkbox"/> BWS / other	<input type="checkbox"/> Chromosomes + Microdeletion FISH (see adjacent list) <input type="checkbox"/> Sex or Other Chromosome Mosaicism <input type="checkbox"/> High Resolution (previous normal result) <input type="checkbox"/> Fibroblast culture for metabolic testing or banking	MICRODELETION FISH ON METAPHASE <input type="checkbox"/> Wolf-Hirschhorn 4p16 <input type="checkbox"/> Cri du Chat 5p15 <input type="checkbox"/> Williams 7q11.23 <input type="checkbox"/> Retinoblastoma 13q14 <input type="checkbox"/> Prader-Willi/Angelman 15q11-q13 <input type="checkbox"/> Miller-Dieker 17p13.3	<input type="checkbox"/> Smith-Magenis 17p11.2 <input type="checkbox"/> DiGeorge/Velocardiofacial Syndrome 22q11.21-q11.23 <input type="checkbox"/> Sex Determining Y Yp11.3 For other probes, please contact lab
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LAB USE ONLY:

Date Set Up: _____	Med. Rec. # _____	Admit # _____	Shire # _____
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