

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 :** _____ **SOC. SEC. #:** _____
DOB: ___/___/___ **SEX:** M / F / Unk **REF. LAB #:** _____ **DATE COLLECTED:** ___/___/___ **DATE RECEIVED:** ___/___/___
 Resp. Party (Relation to Pt): _____ Address: _____ Phone: (____) _____
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: _____
 Address: _____
 City, State, Zip: _____
 Telephone:(____) _____ FAX:(____) _____
ADDITIONAL REPORTS TO:
 Name: _____
 Address: _____
 City, State, Zip: _____
 Telephone: (____) _____ FAX: (____) _____

BILLING INFORMATION: (Check)
 REFERRING INSTITUTION / CLINIC / OFFICE
 Institution Name: _____ Inpatient: Yes No
 Billing Address: _____
 Financial Contact: _____ Telephone: (____) _____
 INSURANCE
Commercial: Provide front / back copy of card
Managed Care (HMO): Copy of card with authorization
Medicaid (MT, WY, CO, UT, CA, ID): Copy of card
 Name of Policy Holder: _____
 Insurance Co / Policy #: _____
 Insurance Co Contact / Phone #: _____
SS # (Guarantor): _____
 Medicaid # / State: _____
 SELF PAY (Please call the laboratory to arrange)

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. 1-800-447-6614, ext. 7532

Blood: Sodium Heparin (green top tube) 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"/> X-linked Ichthyosis Xp22.3 <input type="checkbox"/> Kallmann's Syndrome Xp22.3 <input type="checkbox"/> Sex Determining Y Yp11.3 <input type="checkbox"/> For other probes, please contact lab
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LAB USE ONLY:

Date Collected: ___/___/___	Med. Rec. # _____	Lab #
Date Received: ___/___/___	Admit # _____	
Date Set Up: ___/___/___	Shire # _____	