WARDE MEDICAL LABORATORY
CYTOGENETICS TEST REQUISITION
734-214-0300 800-760-9969 Fax: 734-214-0399

Patient Information

Name: _____
Last First MI

Date of Birth: _____/_____/_____ Gender: _____

Patient ID: _____ Specimen ID: _____

*Referring Physician: _____ * Phone: _____

Fax: _____

*Indication for Test: Clinical
Information _____

_____

Chromosome Analysis/Array CGH

☐ Chromosome Analysis, Constitutional (CHRSP): 10 mL Whole Blood Na Heparin

☐ Reflex to Array CGH (Chromosome Microarray) if chromosome analysis is normal or does not produce optimal results.

☐ Chromosome Analysis, Products of Conception (CHRPCSP): Tissue in Tissue Transport Medium (TTM)

☐ Chromosome Analysis, Skin Biopsy: Tissue in Tissue Transport Medium (TTM)

☐ Array CGH (Chromosome Microarray) (CGH): 10 mL Whole Blood Na Heparin

☐ **Fluorescence *in situ* hybridization (FISH)**

*Specify Probes/Disorder: _____

☐ FISH for Chromosome 21 (TRI21FISH)
☐ Subtelomere FISH (STELFISH)

Specimen Type: _____

Collection Date: _____ Time: _____

Additional Comments: _____

_____

* Required Fields