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, Congenital Disorder (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, Solid Tumor (CHRSTSP) Tissue in Tissue Transport Medium (TTM)
- ☐ Chromosome Analysis, Products of Conception (CHRPCSP) Tissue in Tissue Medium (TTM)

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

Fluorescence *in situ* hybridization (FISH)

- ☐ Genetic Diseases (GENEFISH)**_____
- ☐ Trisomy 21 (TRI21FISH)
- ☐ Subtelomere Abnormality FISH (STELFISH)
- ☐ X & Y (XYFISH)

Specimen Type: _____

Collection Date: _____ Time: _____

Additional Comments: _____

_____

* Required Fields
**Please specify genetic disease suspected