

CYTOGENETICS LABORATORY REQUISITION

Constitutional Studies

Vancouver General Hospital
899 West 12th Avenue, Vancouver, BC, V5Z 1M9
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VGH Cytogenetics Number

Medical Genetics Number

PHYSICIAN INFORMATION		PATIENT INFORMATION	
ORDERING PHYSICIAN	BILLING #	SURNAME	GIVEN NAME(S)
ADDRESS		DATE OF BIRTH (DD/MM/YYYY)	PHN
PHONE #	FAX	GENDER	<input type="checkbox"/> INPATIENT Ward:..... <input type="checkbox"/> OUTPATIENT
GENETIC COUNSELLOR	PHONE #	ADDRESS	

ADDITIONAL REPORTS TO (include first name or billing #):

CONSTITUTIONAL STUDIES

Reason for Testing – REQUIRED	Test Requested
<input type="checkbox"/> Recurrent pregnancy loss } <i>Partner's name:</i> <input type="checkbox"/> Inability to conceive } <input type="checkbox"/> Oligo/azoospermia } <input type="checkbox"/> Klinefelter syndrome } <input type="checkbox"/> Amenorrhea } <input type="checkbox"/> Turner syndrome } <input type="checkbox"/> Premature ovarian failure } <input type="checkbox"/> Developmental delay } <input type="checkbox"/> Autism/ASD } <input type="checkbox"/> Congenital abnormalities <i>Specify below</i> <input type="checkbox"/> Pre-IVF; <i>Date of IVF:</i> <input type="checkbox"/> Family history of chromosome abnormality <i>Specify below</i> <input type="checkbox"/> Other:	<input type="checkbox"/> Karyotype <input type="checkbox"/> FISH – <i>A complete list of FISH probes is available upon request</i> <input type="checkbox"/> DiGeorge/22q11.2 <input type="checkbox"/> STS <input type="checkbox"/> Prader-Willi/Angelman syndrome/SNRPN <small>NOTE: An EDTA blood specimen is required by the Molecular Genetics Lab for PWS/AS methylation studies prior to this FISH assay being performed</small> <input type="checkbox"/> Other: <input type="checkbox"/> Self-pay cytogenetic/FISH studies <input type="checkbox"/> Y-microdeletion studies ◀ <i>This is a self-pay test. Please contact the VGH Cytogenetics Laboratory for payment details</i> <i>Accounts payable/self-pay receipt #</i>

Is patient pregnant? Yes; *LMP:* No

Relevant Clinical/Family History (please describe):

ORDERING PHYSICIAN SIGNATURE – REQUIRED
Signature indicates appropriate counselling has been provided

SPECIMEN REQUIREMENTS *Ship at room temperature, courier overnight, M-Th only.*

- Karyotype, and FISH studies – 5 mL Sodium Heparin Blood
- ◀ Y-microdeletion studies – 5 mL EDTA Blood

COLLECTION INFORMATION

Date: Time:
Location:
Phlebotomist:

CG LABORATORY USE ONLY

Date Received:
Date Incubated:
Log-in Tech:
Number of Cells:
Analyser:

- High Resolution
- C Banding/NOR
- FISH
- Mosaicism
- Y-microdeletion

SPECIMEN(S) RECEIVED

..... NaHep tube
..... EDTA tube
..... Other