



CYTOGENETIC TEST REQUISITION

Signature, Contact of the requesting clinician:	Sampling by:	Date / time of sampling:	Internal file ID:
	Sample received by:	Date / time of sample receipt in the laboratory:	Sample ID:

PATIENT DETAILS

First Name:	Sex: FEMALE MALE	Home Address:
Last Name:		Telephone Number:
Insurance Number:	Date of Birth:	E-mail:
Health Insurance Company:		Diagnosis:

SAMPLE TYPE / SAMPLING SYSTEM		FISH	CHROMOSOMAL EXAMINATION	ARRAY CGH
	Peripheral blood Vacuette - heparin (Green Cap)	Sex chromosomes	Karyotype	
	Amniotic Fluid Vacuette - Yellow Cap	SHOX	Acquired chromosome aberrations	
	Chorionic villi Vacuette - heparin (Green Cap)	DiGeorge syndrome	Cultivation for DNA examination	
	Abortion tissue Sterile Saline Container	PW/A syndrome	Fetal Sex Notification: YES NO	
	Buccal Swab Sterile Nylon Swab	Wolf-Hirschhorn syndrome	ADDITIONAL DATA	
	Fetal blood Vacuette - heparin (Green Cap)	Williams-Beuren syndrome	Gestational age by ultrasound:	
	Other	Painting Probes	Comments:	ADDITIONAL DATA AND NOTES
		Other		