

Cytogenetics Request Form

PAML

P.O. Box 2687 | Spokane, WA | 99220

PAML Cytogenetics Laboratory
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Spokane, WA 99204

Phone: 509-434-1050
Fax : 509-747-2388

PATIENT NAME	SEX	DATE OF BIRTH (Required)
FINANCIALLY RESPONSIBLE PERSON	RELATIONSHIP TO PATIENT	
ADDRESS OF FINANCIALLY RESPONSIBLE PERSON		
INSURANCE	POLICY / GROUP NO.	
REFERRING PHYSICIAN		
REFERRING HOSPITAL / LAB		
DATE SAMPLE DRAWN	TIME SAMPLE DRAWN	
CLINICAL INDICATION (SAMPLE CANNOT BE PROCESSED WITHOUT THIS)		

All Specimens Should Accompany a Requisition Form with Detailed Clinical Indications for Study.

TEST REQUESTED

CYTOGENETIC ANALYSIS: Routine Analysis High-Resolution Mosaicism Family Study

FISH Probe(s) Requested: _____

OTHER: _____

TYPE OF SPECIMEN

PERIPHERAL BLOOD SOLID TISSUE TYPES: _____

BONE MARROW OTHER: (please describe) _____

AMNIOTIC FLUID: _____

COMPLETE FOR ALL AMNIOTIC FLUIDS AND POC'S AS APPROPRIATE

GESTIONAL AGE (WKS LMP):

GESTIONAL AGE (BY ULTRASOUND):

G P SAB

AFP: YES NO

ACHE: YES NO

COMPLETE FOR ALL BONE MARROWS

PREVIOUS BONE MARROW ASPIRATIONS (DATE):

PREVIOUS CYTOGENETIC STUDIES (DATE): CASE # IF KNOWN:

MEDICATION (PAST AND PRESENT):

RADIATION THERAPY:

CHEMOTHERAPY: