



PROVIDENCE HEALTH & SERVICES
CATHOLIC HEALTH INITIATIVES

Cytogenetics Request Form

PAML

P.O. Box 2687 • Spokane, WA 99220
(509) 755-8600 • 1-800-541-7891

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

FAILURE TO COMPLETE REQUISITION WILL RESULT IN DELAYS

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 POCs AS APPROPRIATE

GESTATIONAL AGE (WKS LMP):

GESTATIONAL AGE (BY ULTRASOUND):

AFP: YES NO

ACHE: YES NO

G P SAB

COMPLETE FOR ALL BONE MARROWS

PREVIOUS BONE MARROW ASPIRATIONS (DATE):

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

MEDICATION (PAST AND PRESENT): _____

RADIATION THERAPY: _____

CHEMOTHERAPY: _____