# Cytogenetics Request Form

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**Patient Name**

**Insurance**

**Referring Physician**

**Referring Hospital / Lab**

**Date Sample Drawn**

**Time Sample Drawn**

**Financially Responsible Person**

**Address**

**Policy / Group No.**

**Relationship to Patient**

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## All Specimens Should Accompany a Requisition Form with Detailed Clinical Indications

**Type of Specimen**

- [ ] Peripheral Blood
- [ ] Solid Tissue: Products of Conception or skin biopsies (Fresh or FFPE): Specify
- [ ] Amniotic Fluid
- [ ] Chorionic Villi (CVS)
- [ ] Bone Marrow
- [ ] Solid Tumor (Fresh or FFPE): Specify tissue source
- [ ] Leukemic Peripheral Blood
- [ ] Previous Sex Mismatched Transplant
- [ ] Other:

**Test Requested**

- [ ] Chromosome Analysis: [ ] Routine Analysis [ ] High-Resolution [ ] Mosaicism
- [ ] FISH [ ] Probes/panels Requested:
- [ ] Microarray Analysis: Available for specimen types PB, POC, Fresh Tissue, Amino, CVS, Bone Marrow, Tumor, FFPE Tissue
- [ ] Next Generation Sequencing: 
- [ ] Other:

**Clinical Indication** (Sample cannot be processed without this)

Specify or check boxes below:

* Known Chromosomal Abnormalities, please specify:

**Prenatal** (Amniotic Fluid, CVS)

- [ ] Abnormal Maternal Screen
- [ ] Abnormal Ultrasound
- [ ] Advanced Maternal Age
- [ ] Family History Chromosome Abn.
- [ ] Other

**Postnatal** (PB, Solid Tissue, POC)

- [ ] Developmental Delay
- [ ] Congenital Anomalies
- [ ] Suspected Syndrome
- [ ] Family History Chromosome Abn.
- [ ] Other

**Parental Followup Study**

**Prior Study #**

**Parental Followup Study**

**Short Stature/Amenorrhea/Suspected Turners**

**Spontaneous Pregnancy Loss**

**Fertility/Preconception Workup:**

**R/O Chromosome Abnormality**

**Neoplastic**

(Bone Marrow, Leukemic Blood, Solid Tumor)

**Suspected Disorder**

- [ ] AML
- [ ] CML
- [ ] ALL
- [ ] CLL/SLL
- [ ] Myeloma
- [ ] NHL [ ] SPECIFY
- [ ] Hodgkin Lymphoma
- [ ] Anemia
- [ ] Pancytopenia
- [ ] Thrombocytopenia
- [ ] Leukopenia
- [ ] Thrombocytosis
- [ ] Leukocytosis
- [ ] Other

**Complete for all Amniotic Fluids and POC’s, as Appropriate**

**Gestational Age:**

**BY ULTRASOUND**

- [ ] Yes
- [ ] No

**BY LMP**

- [ ] Yes
- [ ] No

**AFP:**

- [ ] Yes
- [ ] No

**ACHE:**

- [ ] Yes
- [ ] No

**Twin Pregnancy**

**Grow Cells for Additional/Special Testing:**

**Details**

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*Cytogenetics testing reveals the genetic sex of the patient. The lab requires information on the genetic sex in order to properly interpret results.*

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