HealthCare

PATIENT NAME:

University of Kentucky Hospital Chandler Medical Center Lexington, Kentucky 40536

MEDICAL RECORD # :

Cytogenetics Laboratory
Department of Pathology
Phone: (859) 257-3736
FAX: (859) 257-6838

DATE OF BIRTH:

CYTOGENETICS REQUISITION - PRENATAL

Attending Physician	Pager #	Date/Time Specimen Collected:
Requesting Physician	Pager #	

Deliver Specimen to HL423 University of Kentucky Hospital

SPECIMEN (check one):		**CLINICAL INFORMATION:**
	Amniotic Fluid	LMP (Last Menstrual period) _____
	Chorionic Villus Sample	Gestational age by LMP _____
	Cord Blood (1-2 mls in sodium heparin)	Date of Ultrasound _____
	Other _____	Gestational age by Ultrasound _____

CLINICAL DIAGNOSIS (REQUIRED):			
	Advanced maternal age		Screen positive for Trisomy 18
	Screen positive for Down Syndrome		Abnormal Ultrasound _____
	Screen positive for spina bifida		Other _____

Describe additional relevant clinical history here: _____

TESTING REQUESTED (check all that apply):			
	Chromosome analysis		
	Grow additional cells for biochemical/DNA testing Grow extra cells # _____ T-25 flasks (Appropriate requisition and consent forms ***must*** accompany specimen)		
	Chromosome analysis and FISH – *FISH TEST(S) MUST BE SELECTED FROM LIST BELOW*		
	Angelman Syndrome (D15S10)		X and Y centromere probes for sex determination (DXZ1/DYZ3)
	DiGeorge sequence/Velo-Cardio-Facial syndromes 22q11.2 Tuple1(HIRA)		SRY (Sex Determinig Region of Y)
	Prader-Willi syndrome (SNRPN)		Aneuploidy screen
	Other _____		

LAB USE ONLY

CG Date/Time received _____ CDM's _____ 6/1/2017