

THIS IS NOT A TEST REQUEST FORM.
The information below is required to perform cytogenetic (chromosome) studies.
Please fill out this form and submit it with the test request form or electronic packing list.

PATIENT HISTORY FOR PEDIATRIC/ADULT CYTOGENETIC (CHROMOSOME) STUDIES

Patient Name _____ Date of Birth ____/____/____ Gender F M
 Physician Name _____ Physician Phone (____) _____
 Practice Specialty _____ Physician SECURE FAX (____) _____
 Genetic Counselor _____ Counselor Phone (____) _____

CLINICAL INFORMATION

Sample Type: Peripheral blood Cord blood Buccal Skin Biopsy

Study Type:

Chromosome analysis (karyotype) Newborn FISH panel (13, 18, 21, X, Y)
 Genomic microarray (aCGH) FISH for specific condition: (specify) _____
 Chromosomes with reflex to microarray

Indication for testing (please check all that apply - *required*):

Suspected diagnosis of: Down syndrome Trisomy 18 Trisomy 13 Bloom syndrome
 Fanconi anemia Ataxia telangiectasia Sex chromosome abnormality

Cardiac defect (specify) _____
 Multiple congenital anomalies (specify) _____
 Intellectual and/or developmental disability
 Autism/Autism spectrum disorder
 Pervasive developmental delay (PDD)
 Learning disabilities
 Dysmorphic features (specify) _____
 Genital anomalies
 Ambiguous genitalia
 Infertility
 Recurrent miscarriage
 Partner with recurrent miscarriage
 (Partner's Name) _____
 Other (specify) _____

Master Label

Is this test to see if the patient carries a chromosome variant already identified in a family member?
 Yes No

IF YES, to ensure correct testing, please provide:

1. The name of the previously tested family member: _____
2. The abnormality found in that family member: _____
3. A copy of that family member's test results.

Please contact an ARUP genetic counselor at (800) 242-2787, ext. 2141 prior to sending sample to help ensure that the correct test is ordered.