ARUP LABORATORIES

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

PATIENT HISTORY FOR CYTOGENETIC (CHROMOSOME) STUDIES

Patient's Name _____ Date of Birth_____/_____/_____ Gender [ ] F [ ] Male

Physician_____ Physician Phone (_____)_____ Practice Specialty _____

Genetic Counselor _____ Counselor Phone (_____)_____

PRENATAL/PEDIATRIC/ADULT CONSTITUTIONAL STUDIES

Indication for testing (check all that apply - required):
__ Abnormal maternal serum screen__T21__T18__ONTD
__ Abnormal ultrasound (specify) _____
__ Advanced maternal age
__ Cardiac defect (specify) _____
__ Multiple congenital anomalies
__ Developmental delay/mental retardation
__ Learning disabilities
__ Dysmorphic features
__ Ambiguous genitalia
__ Infertility
__ Recurrent miscarriage
__ Partner with recurrent miscarriage
__ Familial translocation/inversion (specify) _____
__ Previous child with chromosome abnormality (specify)
_____
__ Other (specify)_____

Sample Type:
__ Whole blood
__ Amniotic fluid
__ CVS
__ PUBS
__ Cord blood (newborn or stillborn infant)
__ Tissue: __ POC __ Skin Biopsy

Study Type:
__ Routine analysis
__ FISH (specify condition or probe) _____
__ Chromosomal microarray
__ Family study
Name of studied individual _____
Relationship to patient? _____
What was their result? (Attach report if available)
_____

ONCOLOGY

Diagnosis: _____

Is this a new diagnosis? [ ] Yes [ ] No
Is this a repeat study? [ ] Yes [ ] No

WBC: _____ % Blasts: _____

Has the patient had a bone marrow transplant? [ ] Yes [ ] No
If yes, what was the sex of the donor? [ ] Male [ ] Female
Has the patient had previous radiation or chemotherapy? [ ] Yes [ ] No

Sample Type:
__ Whole Blood
__ Bone Marrow
__ Bodily Fluid – specify source_____
__ Solid Tumor – specify source_____

Study Type:
__ Lymphoid Disorder
__ Myeloid Disorder
__ FISH –specify probe(s) and/or condition _____
_____

Master Label