Penn Medicine

CYTOGENETICS TEST REQUISITION

Phone 215-662-4937
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Address University of Pennsylvania
3020 Market Street, Suite 220
Philadelphia, PA 19104

Patient Label

☐ Inpatient ☐ Outpatient

Patient Name	MRN	Gender ☐ Male ☐ Female	DOB

Diagnosis (**required**)	Relevant History
ICD10 Code(s)	Donor Gender ☐ Male ☐ Female

Specimen Collection Date and Time (**required by law**)	WBC	Blasts	ALC
/ / : AM / PM			

Specimen Type
☐ Bone Marrow -------in Sodium Heparin (green top)
☐ Bone Core ------in Media or Saline
☐ Peripheral Blood---in Sodium Heparin (green top)
☐ Lymph Node---in Media or Saline
☐ FFPE Slide:
☐ Other:

Physician	Phone	☐ HUP ☐ PPMC ☐ Other: _____

Requested Studies ☐ Conventional Karyotype
☐ FISH – specify probe(s): _____

Cytogenetics Laboratory Use Only

Received Date and Time: ____/____/____:____AM/PM
Specimen Container and Volume: _____
FFPE Slides Number: _____

Setup Date: _____ Tech:_____
1) 24h ☐ RPMI -------x _____
2) 24h ☐ MMAX------x _____
3) 72h ☐ PWM -------x _____
4) 72h ☐ PHA --------x _____
5) 72h ☐ ODN -------x _____
☐ Direct Harvest for FISH
☐ Clotted ☐ Collagenase Treated

Case Number

CG: C- _____
Billing: _____
Credit(s): _____

FISH: C- _____
Billing: _____
Credit(s): _____