(Place MR Label Here)
MR#:
Patient's Name:
Patient's Address:

UAMS Medical Center
Cytogenetics Laboratory - Mail Slot 834
Freeway Medical Suite 200
5800 West 10th Street
Little Rock, AR 72204
Phone (501) 526-8000 ext 1 Fax (501) 526-7468

UAMS MEDICAL CENTER
UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

Cytogenetics Test Request - To Accompany Specimen

Patient Name (or put stamp/label above): _____

Date of Birth: _____ Sex: M F Referring Institution's Patient ID#: _____

Blood / Body Fluid Precautions? [ ] **Yes** [ ] **No** Specify: _____

Hospital / Clinic: _____ Phone: _____ Fax#: _____

Hospital Mailing Address: _____
Street City State Zip

Referring Physician: _____ Phone: _____ Fax#: _____

Physician Signature: _____ Date: _____ Time: _____

Physician Address: (address to send final report) _____
Street Dept/Slot# City State Zip

Tests CANNOT be ordered without referring physician's name, diagnosis and the appropriate test selected

SUPPLY REQUEST [ ] Specimen containers [ ] Test request forms

HEMATOLOGIC DISORDER

[ ] **BONE MARROW** (3 ml)
[ ] **SPINAL FLUID (CSF)** (10 ml)
[ ] **PLEURAL FLUID** (45 ml)
[ ] **LEUKEMIC BLOOD** (10 ml, > 5% Blasts) White blood cell count: _____
[ ] **FINE NEEDLE ASPIRATE** (specify site) _____
[ ] **LYMPH NODE** (specify site) _____

Date drawn: _____ Time: _____ Amount: _____

Indication for test (must include):

[ ] Original sample
[ ] New diagnosis
[ ] Remission sample
[ ] Relapse sample
[ ] Presently on chemotherapy

[ ] **Multiple Myeloma**
[ ] **CML:** [ ] **Chronic Phase** [ ] **Blast Phase**
[ ] **CLL**
[ ] **ALL**
[ ] **ANLL:** [ ] **AML (M1, M2)** [ ] **APL (M3)**
[ ] **AMMoL (M4)** [ ] **AMoL (M5)** [ ] **EL(M6)**
[ ] **Myeloproliferative Disorder:** (specify) _____
[ ] **Dysmyelopoietic Syndrome:** (specify) _____
Other: _____

Post bone marrow transplant: [ ] **No** [ ] **Yes, mm/yy of transplant:** ____/____ **Donor: M F** [ ] **autologous**

Previous chemotherapy: [ ] No [ ] Yes, (mm/yy) ____/____ Previous radiation therapy: [ ] No [ ] Yes, (mm/yy) ____/____

SOLID TUMOR

[ ] **Tumor chromosome analysis**

Date collected: _____ Time: _____ Specimen was taken under sterile conditions: [ ] Yes [ ] No

Diagnosis: _____ **Type and Location:** _____

Access specimen procurement details at:
http://www.uams.edu/clinlab/Cytogenetics_Laboratory.htm

To print requisitions select form 2441 Lab Requisition Cytogenetics
http://intranet.uams.edu/OnDemandForms/OnDemandFormRequest.aspx (networked printer required)

or print from the PrintProfile screen, Special Forms line in Medipac/RegWorkstation

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Cytogenetics Test Request

PERIPHERAL BLOOD

[ ] **Routine blood chromosome analysis**
[ ] **Yes** [ ] **No** Is **Rapid Culture and Analysis** (48 hrs) requested? (additional charge)

Collect 5 ml for adults and 1-3 ml for infants in a **sodium heparin** vacutainer.

Caution: Do not use lithium heparin. Do not transport on ice.

Date Drawn: _____ Time: _____ Amount: _____

Indication for test (must include)

[ ] Trisomy (circle) 13 18 21
[ ] Turner Syndrome 45,X
[ ] Multiple congenital anomalies
[ ] Other: _____
[ ] Developmental delay
[ ] Klinefelter Syndrome 47,XXY
[ ] Multiple spontaneous abortions # _____ Trimester (circle) 1 2 3
Mosaicism suspected: [ ] Yes [ ] No

FISH: Flourescence In-Situ Hybridization (for microdeletion syndromes)

FISH should not be regarded as a "stand-alone" diagnostic test. It is a recommendation of the American College of Medical Genetics that metaphase chromosomes be done with FISH in order that other possible structural or numerical chromosome abnormalities are detected.

[ ] Microdeletion Syndrome: 1p36
[ ] Wolf-Hirschhorn: 4p16.3
[ ] Cri-du-Chat: 5p15.2
[ ] Williams (Elastin Gene): 7q11.23
[ ] Prader Willi/Angelman: 15q11-q13
[ ] Smith Magenis: 17p11.2
[ ] Miller-Dieker: 17p13.3
[ ] DiGeorge / VCFS Region: 22q11.2
[ ] SRY (Sex Determining Region Y): Yp11.3
[ ] Subtelomere Probe Panel
[ ] Other: _____

TISSUE CULTURE (non-neoplastic)

[ ] **Tissue chromosome analysis** [ ] **Metabolic studies** **Mycoplasma testing required:** [ ]**Yes** [ ]**No**

Lab/Party to notify when fibroblast cultures are ready to send for metabolic testing: _____

Date collected: _____ Time: _____ Type of tissue: _____

Specimen was taken under sterile conditions: [ ] Yes [ ] No

Indication for test (must include)

[ ] Products of conception (gestational age: _____)
[ ] Metabolic test (specify): _____
[ ] Autopsy: _____
[ ] Other: _____

Physician Signature: _____ **Date:** _____ **Time:** _____

PRELIMINARY RESULTS

Date: _____ To: _____ By: _____

Report: _____

Cytogenetics Label

(lab use only)

COMMENTS: _____

Computer Sign-out: Date: _____ By: _____ Report Mailed Out: Date: _____ By: _____

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