UCLA Health System

PRENATAL CLINICAL CYTOGENETICS Requisition Form

Procedure: CYTO 012

Effective: 01/01/12

Please provide all pertinent information

UCLA Cytogenetics Lab accession Number: ______________________

PATIENT INFORMATION	SPECIMEN INFORMATION
ID #	**Collection date:** **Time:**
Name: Last **First** **MI**	**Collected by:** (Cytogenetics lab use only) Date Received by Lab: Time: Tech:
Date of birth: **Sex: M F** **Ethnicity**	**TYPE OF SPECIMEN: O** Amniotic Fluid **O** Chorionic villus **O** PUBS **O** Products of Conception **O** Other **O** Blood VOLUME SENT:________ML # OF TUBES: _____ APPEARANCE:

REFERRAL PATIENTS: PLEASE PROVIDE COMPLETE BILLING INFORMATION –SEE REVERSE SIDE

REPORTING INFORMATION:

Ordering physician: _______________________________UPIN # ___ ___ ___ ___ ___Phone/Pager: ___________ FAX:___________

Send copy to: ____ Address: ____

Genetic Counselor_________________________________Phone #: ____________________FAX#: ____________________

Notice to ordering physicians: Medical necessity for the test(s) requested must be indicated by ICD-9 codes. ICD-9: _______

TEST REQUESTED: *CHROMOSOME FISH ANALYSES INCLUDE PATHOLOGIST'S INTERPRETATION AND CONSULTATION.*

[ ] Chromosome analysis O Culture only O Save Cells O Interpretation and consultation not requested

O Save Cells for Microarray O Other ___________________________ **O AF-AFP and ACHE**.

[ ] FISH (Always done in conjunction with karyotype)**-**Please provide a 3rd tube of fluid (~ 5mL) if possible. Please select probes

O X/Y/13/18/21 **O deletion 22q11.2 O STS O Other** ____________________________________

CLINICAL INDICATIONS / DIAGNOSIS FOR CHROMOSOMAL STUDIES:

O Advanced Maternal Age ___________ years **O** Expanded AFP **O** Trisomy 13/18 risk **O** Trisomy 21 risk **O** NTD

O Abnormal Ultrasound (Specify) ____

O Family History of genetic/chromosome disorder: ___________________________________ **O** Other**:** ______________________

OBSTETRIC / PATIENT INFORMATION:

G_____P_____A_____ [SAB____TAB____]

Gestational Age: Date of LMP: ____________ Date of Ultrasound: ____________ GA by BPD:___________

O THE PATIENT DOES NOT WANT TO KNOW THE GENDER OF THE FETUS, and

O The cytogenetics lab should **NOT** reveal the gender to the **physician** or the **physician's staff**.

SPECIMEN COLLECTION: KEEP ALL SAMPLES AT ROOM TEMPERATURE!!

Amniotic Fluid: (Discard the first 2mL of fluid) GA of >15 weeks: **30mls** of fluid; GA of 10-14 weeks: **20mls** of fluid

CVS: minimum 20mg (Direct CVS upon request only) **PUBS**: 1-2mls in a Sodium Heparin tube **Adult blood**: 5-7mL in Sodium Heparin tube

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UCLA HEALTH SYSTEM/ CLINICAL LABORATORIES

SEND ALL SPECIMENS TO THIS ADDRESS
UCLA Cytogenetics Center
1000 Veteran Avenue (Rehabilitation Center) Room: 2-226
Los Angeles, CA 90024 Phone: (310) 794-1287
Fax: (310) 794-4139