Constitutional Cytogenomics Requisition

I N P A T I E N T

Floor/Room#

Date Specimen Collected: _____

Yale Cytogenetics Laboratory
Department of Genetics
WWW335, 333 Cedar Street
New Haven, CT 06510
Phone: 203-785-2146 Fax: 203-785-7342
http://medicine.yale.edu/labs/cytogenetics/

Patient Identification or Place sticker here

Patient Name (Last, First) **Location**

MRN# **DOB** **Sex**

_____ __/__/__ M / F / Amb.

For cytogenetic lab use only

Lab #:
Date/Time:
Tech Initial:

Specimen Information

- ☐ **Peripheral Blood (3-5 ml in Sodium Heparin vacutainer)**
- ☐ **Chorionic Villi (15-45mg)**
- ☐ **Products of Conception (villi / skin)**
- ☐ **Amniotic Fluid (15-25ml)**
  - ☐ **AFP Y / N**
- ☐ **Skin biopsy**
- ☐ **Other tissue, specify site/type** _____

Important: Tissue samples should be placed in sterile transport media (RPMI/MEM) or balanced salt solution (HEPES), all samples must be received in appropriate media within 24 hours of procedure. Contact the lab for transport media if needed.

Clinical Information

Clinical Diagnosis:

Physical Findings:

ICD9 Code:

IS SUBJECT PREGNANT: ☐ **YES** ☐ **NO**

LMP:_____

US Gest Age:____**wks**___**days**

MENTAL RETARDATION: ☐ **YES** ☐ **NO** **DEVELOPMENTAL DELAY:** ☐ **YES** ☐ **NO**

Check if patient has or may have: ☐ **AIDS** ☐ **Hepatitis** ☐ **EB Virus**

Test Requested

☐ **Karyotype (G-band Chromosome Analysis)**

☐ **Genomic Microarray Analysis (Oligonucleotide Array Comparative Genomic Hybridization--aCGH)**

Note: ACMG recommends aCGH as first tier genetic evaluation for DD/MR/Congenital Anomalies/Autism

☐ **Fluorescence In Situ Hybridization**

- ☐ Angelman syndrome (15q12-)
- ☐ Cat-eye syndorome (22q11.2++)
- ☐ Cri-du-Chat syndrome (5p-)
- ☐ Charcot-Marie-Tooth (17p12+)
- ☐ DiGeorge syndrome I (22q11.2-)
- ☐ Hereditary neuropathy with liability to pressure palsies (HNPP, 17p12-)
- ☐ Isolated Lissencephaly (17p13.3-)
- ☐ Kallman syndrome (Xp22.3-)
- ☐ Miller Dieker syndrome (17p13.1-)
- ☐ Pallister-Killian syndrome (12p++)
- ☐ Prader-Willi syndrome (15q12-)
- ☐ Saethre-Chotzen syndrome (7p21.1-)
- ☐ Sex reversal, SRY (Yp11.2-/+)
- ☐ Smith Magenis syndrome (17p11.2-)
- ☐ Steroid sulfatase def (Xp22.3-)
- ☐ WAGR/Wilm's Tumor (11p13-)
- ☐ Williams syndrome (7q11.23-)
- ☐ Wolf-Hirschhorn syndrome (4p-)

Other FISH Tests

- ☐ Prenatal AneuVysion (13/21, XY/18)
- ☐ Clarify complex rearrangement
- ☐ Identify marker chromosome, sSMC
- ☐ Confirm genomic imbalance
- ☐ Subtelomeric probes, specify: _____
- ☐ Other, specify: _____

Referring Physicians (information required for reporting)

MD:	**MD:**
Address:	**Address:**
Phone:	**Phone:**
Fax:	**Fax:**

Consent for Testing _____

I hereby authorize Yale Cytogenetics Lab to perform the selected test(s) on this patient, as well as any additional FISH test(s) deemed clinically necessary. I also authorize the lab to preserve for scientific or teaching purposes or otherwise dispose of any residual sample material not needed for diagnosis.