

Constitutional Cytogenomics Requisition

OUTPATIENT

Date Specimen Collected: _____



Yale Cyto genetics Laboratory

Department of Genetics

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<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	
<input type="checkbox"/> Peripheral Blood (3-5 ml in Sodium Heparin vacutainer) <input type="checkbox"/> Chorionic Villi (15-45mg) <input type="checkbox"/> Products of Conception (villi / skin) <input type="checkbox"/> Amniotic Fluid (15-25ml) <input type="checkbox"/> AFP Y / N <input type="checkbox"/> Skin biopsy <input type="checkbox"/> 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:	ICD9 Code:
Physical Findings:	IS SUBJECT PREGNANT: <input type="checkbox"/> YES <input type="checkbox"/> NO
MENTAL RETARDATION: <input type="checkbox"/> YES <input type="checkbox"/> NO DEVELOPMENTAL DELAY: <input type="checkbox"/> YES <input type="checkbox"/> NO	LMP: _____
Check if patient has or may have: <input type="checkbox"/> AIDS <input type="checkbox"/> Hepatitis <input type="checkbox"/> EB Virus	US Gest Age: ___ wks ___ days

Test Requested		
<input type="checkbox"/> Karyotype (G-band Chromosome Analysis)		
<input type="checkbox"/> Genomic Microarray Analysis (Oligonucleotide Array Comparative Genomic Hybridization--aCGH) Note: ACMG recommends aCGH as first tier genetic evaluation for DD/MR/Congenital Anomalies/Autism		
<input type="checkbox"/> Fluorescence In Situ Hybridization		
<input type="checkbox"/> Angelman syndrome (15q12-) <input type="checkbox"/> Cat-eye syndrome (22q11.2++) <input type="checkbox"/> Cri-du-Chat syndrome (5p-) <input type="checkbox"/> Charcot-Marie-Tooth (17p12+) <input type="checkbox"/> DiGeorge syndrome I (22q11.2-) <input type="checkbox"/> Hereditary neuropathy with liability to pressure palsies (HNPP, 17p12-) <input type="checkbox"/> Isolated Lissencephaly (17p13.3-) <input type="checkbox"/> Kallman syndrome (Xp22.3-)	<input type="checkbox"/> Miller Dieker syndrome (17p13.1-) <input type="checkbox"/> Pallister-Killian syndrome (12p++) <input type="checkbox"/> Prader-Willi syndrome (15q12-) <input type="checkbox"/> Saethre-Chotzen syndrome (7p21.1-) <input type="checkbox"/> Sex reversal, SRY (Yp11.2-/+) <input type="checkbox"/> Smith Magenis syndrome (17p11.2-) <input type="checkbox"/> Steroid sulfatase def (Xp22.3-) <input type="checkbox"/> WAGR/Wilm's Tumor (11p13-) <input type="checkbox"/> Williams syndrome (7q11.23-)	<input type="checkbox"/> Wolf-Hirschhorn syndrome (4p-) Other FISH Tests <input type="checkbox"/> Prenatal AneuVysion (13/21, XY/18) <input type="checkbox"/> Clarify complex rearrangement <input type="checkbox"/> Identify marker chromosome, sSMC <input type="checkbox"/> Confirm genomic imbalance <input type="checkbox"/> Subtelomeric probes, specify: _____ <input type="checkbox"/> Other, specify: _____

Referring Physicians (information required for reporting)	
MD:	MD:
Address:	Address:
Phone:	Phone:
Fax:	Fax:

Consent for Testing _____ <i>I hereby authorize Yale Cyto genetics 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.</i>
