UF PathLabs
UNIVERSITY of FLORIDA

aCGH MICROARRAY TESTING REQUISITION FORM

UF PathLabs - Cytogenetics
4800 SW 35th Drive
Gainesville, FL 32608

please see other Cytogenetic Request forms for testing not listed here or visit:
http://pathlabs.ufl.edu/services/cytogenetics

Telephone: (352) 265-9900
Toll Free: 1-888-375-5227
FAX: (352) 265-9920

Patient Information

Name: ______________________________

Medical Record No.: ______________________

Age or D.O.B.: ___________________________

Sex/Gender: ☐Female ☐ Male ☐Unknown

Requesting Physician Information

Name:_____________________ NPI #:__________

Location/Institution:

Signature:________________________________

Send Additional Reports To: ______________________

Clinical Indication or Reason for Microarray Request

☐ ***Growth:***	☐ ***Developmental:***	☐ ***Cognitive:***	☐ ***Behavioral:***
☐failure to thrive	☐global delay	☐mental retardation	☐autistic features
☐short stature	☐speech delay	☐intellectual disability	☐autism spectrum d/o
☐obesity	☐gross motor delay	☐learning disability	☐OCD
☐ __________	☐ __________	☐ __________	☐ __________
☐ ***Neurological:***	☐ ***Cardiac:***	☐ ***Craniofacial:***	☐ ***various:***
☐seizures	☐ASD	☐cleft lip	☐hearing loss
☐brain anomaly	☐VSD	☐cleft palate	☐ambiguous genitalia
☐ataxia	☐AV canal defect	☐microcephaly	☐limb anomaly
☐hypotonia	☐hypoplastic lft hrt	☐macrocephaly	☐vertebral anomaly
☐dystonia	☐ *Tetrology of Fallot*	☐facial dysmorphism	☐polydactyly
☐spasticity	☐coarctation of aorta	☐coloboma	☐kidney/urological
☐ __________	☐ __________	☐ __________	☐ __________

☐Other (*please list):*____

☐Family history of chromosome abnormality *(please explain):*

____

Array Platform Requested

☐ **180k ISCA**
(current "in house" aCGH platform recommended for congenital applications)

(designs available by special requests only, please contact the laboratory prior to ordering)

☐44k *EmArray* Cyto6000 ☐CGH+SNP ☐ 180k ISCA

PARENTAL STUDIES, *as needed, t*o determine mechanism of origin

*Reference/proband Case*_______________________________

☐ **Chromosome with metaphase FISH studies**, ☐ ***if necessary*** current aCGH design
chromosome and/or FISH studies are recommended for first tier parental carrier status in most cases.

Specimen Information

☐ Peripheral blood

☐ Skin

☐ Other - *Indicate Type*:

____

Date Collected:__________

Time Collected:__________

A conventional or classic chromosome study (aka karyotyping) has been previously conducted for this patient:

☐YES ☐NO ☐Unknown

For Lab Use Only

*Lab No.:*______________________

*Test Codes:*____________________

Specimen Description:

____

____

*Tech Login ID.:*__________

Insurance/Billing Information *(must be completed prior to sample processing)*

Insurance Provider: ______________________________________

Pre-Authorization Required: ☐YES ☐NO

If Yes, Please provide Authorization Number: ____________________

Insurance payment will be filed as courtesy; however the patient is ultimately responsible for payment for the balance of the account.

PHOTOCOPY AS NEEDED