UFHealth
PATHOLOGY LABORATORIES
University of Florida Health
Pathology Laboratories • Cytogenetics
4800 SW 35th Drive • Gainesville, FL 32608

aCGH MICROARRAY TESTING REQUISITION FORM

Reference our other cytogenetics requisition forms for additional tests not listed here, or visit us online at:

pathlabs.ufl.edu/services/cytogenetics

Telephone: 352.265.9900
Toll-Free: 888.375.5227
Fax: 352.265.9920

Patient Information

Name: ____________________

Medical Record #: ____________________

Age or DOB: ____________________

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	☐ Tetralogy of Fallot	☐ Facial dysmorphism	☐ Polydactyly
☐ Spasticity	☐ Coarctation of aorta	☐ Coloboma	☐ Kidney/Urological
☐ __________	☐ __________	☐ __________	☐ __________

☐ Other (*please list*): ____________________

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

____

Specimen Information

☐ Peripheral blood

☐ Skin

☐ Other (*indicate type*):

____

Collection date: __________

Collection time: __________

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

☐ Yes ☐ No ☐ Unknown

For Lab Use Only

Lab #: __________

Test codes:

____

Specimen description:

____

____

Tech login ID: __________

Array Platform Requested

☐ **CGH+SNP**
(current in-house aCGH platform recommended for congenital applications)

(Designs available by special requests only; contact the laboratory prior to ordering.)

☐44k *EmArray* Cyto6000 ☐**180k ISCA**

PARENTAL STUDIES (*as needed,* to 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.

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

Insurance provider: ____________________

Preauthorization required?: ☐ Yes ☐ No

If yes, provide the authorization number: ____________________

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