PRENATAL CYTOGENETIC TESTING REQUISITION FORM

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

Name: ___________________________ NPI #: __________

Location/Institution: _______________________________________

Signature: ____________________________

Send additional reports to: _______________________________________

Clinical Indication or Reason for Cytogenetic Testing

☐ Abnormal NIPT screen result: ________________________________

☐ Advanced maternal age  ☐ IUGR  ☐ FDIU  ☐ Choroid plexus cysts

☐ Abnormal ultrasound findings: ________________________________

☐ Family history of chromosome abnormality (explain): ________________

Cytogenetic Testing Requested (must be completed to avoid delays in processing)

Prenatal (active) applications:
☐ Routine conventional chromosome analysis (aka karyotyping)

☐ Cell line buildups (for outside laboratory testing)
  Specify type/test/provider: ________________________________

Products of conception applications only:
☐ Routine conventional chromosome analysis only (aka karyotyping)

☐ Routine conventional chromosome analysis with reflex CGH+SNP microarray*

Reflex genomic chromosomal microarray testing may be available when tissue culture is unsuccessful and/or where results of a chromosome analysis are normal. Reflex genomic chromosomal microarray testing, however, may not be performed in the absence of identifiable fetal tissues (e.g., only maternal decidua/uterine lining tissues).

* The current in house/ default aCGH platform is recommended for constitutional applications; inquire on the availability of alternate platforms/designs before ordering.

Specimen Information

Call UF Health Pathology Laboratories at 352.265.9900 if you wish to obtain collection containers and/or transport tissue culture medium.

☐ Amniotic fluid

☐ Chorionic villi
  Estimated weight: __________

☐ Fetal blood

☐ Products of Conception
  Fetal tissues only; fetus proper and placental tissues (villi preferred)
  • No fixed or FFPE specimens
  • No umbilical cord samples

Collection date: ____________________
Collection time: ____________________

For Lab Use Only

Lab #: ___________________________

Test codes: _________________________

Specimen description: __________________
______________________________

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.