UF Health
PATHOLOGY LABORATORIES

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

# PRENATAL CYTOGENETIC 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: _____

Gestational age: _____ by ☐ LMP ☐ Ultrasound

Fetal sex: ☐ Undetermined ☐ Female ☐ Male

## Requesting Physician Information

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.*

## 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.*

## 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:*

_____

_____

*Tech login ID:* _____