UF PathLabs
UNIVERSITY of FLORIDA

UF Cytogenetics Laboratory
4800 SW 35th Drive
Gainesville, FL 32608

PRENATAL CYTOGENETIC TESTING REQUISITION FORM

(please use the Standard or Oncology Cytogenetic Request forms for all other studies)

Telephone: (352) 265-9900
Toll Free: 1-888-375-5227
FAX: (352) 265-9920
http://www.pathlabs.ufl.edu/

Patient Information

Name: ______________________________________

Medical Record No.: ______________________________

Age or D.O.B.: __________________________________

Gestational Age: _________ by ☐LMP ☐Ultrasound

Requesting Physician Information

Name:___________________________ NPI #:__________

Location/Institution:

Signature:____

Send Additional Copies of Report to:

____

Clinical Indication or Reason for Cytogenetic Testing

☐Advanced maternal age ☐Elevated AFP

☐Abnormal triple screen test ☐Abnormal quad screen test

☐Choroid plexus cysts ☐IUGR ☐FDIU

☐Abnormal ultrasound findings: _______________________________________

☐Family history of chromosome abnormality (explain)_______________________

☐Other:

____

Specimen Information

☐Amniotic fluid

☐Chorionic villi
Estimated weight: ____________

☐Fetal blood ☐P.O.C.

Date Collected:__________________

Time Collected:__________________

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

☐Routine Chromosome Analysis (Karyotyping)

☐FISH Analysis *(must accompany a conventional chromosome study; please inquire as to availability prior to ordering)*

Specify Type: ____

☐ Cell line build-ups (for outside laboratory testing)

Specify Type: ____

☐ AFP* ☐ AchE*

**AFP and AchE testing is performed by an outside laboratory. Arrangements can be made for our laboratory to forward residual amniotic fluid supernatant for this form testing, if desired.*

For Lab Use Only

*Lab No.:*_________________________

*Test Codes:*______________________

Specimen Description:

____

____

Tech Login ID.: __________

*Database Entry by:*__________

Prenatal Request.doc

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.