UFHealth
PATHOLOGY LABORATORIES

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

STANDARD (CONSTITUTIONAL) 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: _____

Sex/Gender: ☐ Female ☐ Male ☐ Unknown

Requesting Physician Information

Name: _____ NPI #: _____

Location/Institution: _____

Signature: _____

Send additional reports to: _____

Clinical Indication or Reason for Cytogenetic Testing

☐ Trisomy 21 ☐ Mental retardation ☐ Turner syndrome ☐ Multiple fetal loss

☐ Trisomy 18 ☐ Developmental delay ☐ Klinefelter syndrome ☐ Infertility

☐ Trisomy 13 ☐ Dysmorphic features ☐ XYY syndrome ☐ Ambiguous genitalia

☐ Fetal demise ☐ Failure to thrive ☐ XXX syndrome ☐ MCA

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

☐ Other: _____

Specimen Information

☐ Peripheral blood

☐ Skin ☐ POC

☐ Other *(indicate type)*:

_____

Collection date: _____

Collection time: _____

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

Conventional Chromosome Analyses
(Karyotyping)

☐ Routine/Conventional chromosome study

☐ Other

Please specify: _____

☐ Cell line buildup for additional and/or outside studies

Please specify: _____

FISH Analyses
All requests for FISH analysis must include a routine chromosome study.

☐ 22q11.2 - DiGeorge/VCF syndromes

☐ Yp11.3 - SRY ☐ X/Y

Other :_____
(inquire on availability)

Note: *Metaphase FISH testing previously offered for microdeletion and/or microduplication syndromes is now facilitated by comparative genomic hybridization microarray (aCGH) testing methods.*

A **CGH+SNP microarray** *is the current in- house aCGH platform recommended for congenital applications and can be ordered by utilizing a separate requisition form available on our website or by calling* ***352.265.9900****.*

For Lab Use Only

Lab #: _____

Specimen description: _____

# of containers: _____ *Quantity (ml):* _____

☐ *Sodium heparin tube*

Other:

_____

Additional test codes: _____

_____

Tech Login ID: _____

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

Insurance provider: _____

Preauthorization required?: ☐ Yes ☐ No

If yes, provide the authorization number: _____