Special Diagnostic Chemistry
Albany Medical Center
43 New Scotland Avenue
Albany, NY 12208
Ph: 23519 Fax: 28257

MR#:
Pt. Name:
DOB:
Pt. Location:

Inpatient Cytogenetics Requisition

Coll Date:____________ Coll Time:_______ Collected by _______

Ordering Physician________________________ Pager #:_______________ Fax:________________

Clinical Indications:
____

____

*Consent Required
I attest that this patient has been informed about and has given consent for the test(s) I have ordered below.

Physician Signature:_____________________________________

DO NOT USE THIS FORM FOR HEMATOLOGY/ONCOLOGY REQUESTS

* Peripheral Blood (non leukemic)
(Green top, sodium heparin)

- ☐ Chromosome Analysis
- ☐ High Resolution Chromosome Analysis
- ☐ DEB Breakage Study (Chromosomes included)
- ☐ Mosaicism
- ☐ InSight (FISH for 13, 18, 21, X and Y)
- ☐ FISH Angelman/ Prader - Willi *(do not use for Prader - Willi Methylation)*
- ☐ FISH DiGeorge/VCF (22q11)
- ☐ Other FISH (specify)_________________________

* POC / Fetal Tissue
(RPMI Media)

Sample site:__________________________________

- ☐ Chromosome Analysis
- ☐ InSight (FISH for 13, 18, 21, X and Y) ***Chorionic Villi Only***
- ☐ Other ____________________

* Amniotic Fluid

- ☐ Chromosome Analysis
- ☐ InSight (FISH for 13, 18, 21, X and Y)
- ☐ FISH other than InSight (specify)_____________

- ☐ AF – AFP (alpha fetoprotein)
  Note: Elevated amniotic fluid AFP will result in AChE testing at additional charge

Date of ultrasound _________
GA on date of US_______weeks______days
Date of LMP ___________
GA by LMP _________ weeks _________days

Patient Ethnicity:
☐ Caucasian ☐ Hispanic ☐ African American ☐ Asian
☐ Native American ☐ Other _____________

Deliver sample directly to Laboratory Receiving, C126
Testing will be performed by Integrated Genetics Laboratory