

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

UF Cytogenetics Laboratory
Diagnostic Reference Laboratories
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<http://www.pathology.ufl.edu/~drl/cyto/cytolab.htm>

Patient Information

Requesting Physician Information

Name: _____

Medical Record No.: _____

Age or D.O.B.: _____

Gestational Age: _____ by LMP Ultrasound

Name: _____ UPIN#: _____

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: _____

For Lab Use Only

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 amniotic fluid specimens for this testing.*

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.

Lab No.: _____

Test Codes: _____

Specimen Description: _____

Tech Login ID.: _____

Database Entry by: _____

Prenatal Request.doc