

(please use the Standard or Oncology Request forms for all other studies)
 University of Florida Cytogenetics Laboratory • Diagnostic Reference Laboratories
 4800 SW 35th Drive, Gainesville, FL 32608
 Telephone: (352) 265-9900 • Toll Free: 1-888-375-5227 • FAX: (352) 265-9920

Patient Information

Name: _____
 Medical Record No.: _____
 Age or D.O.B.: _____
 Gestational Age: _____ by LMP Ultrasound

Requesting Physician Information

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: _____

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.

For Lab Use Only

Lab No.: _____
 Test Codes: _____
 Specimen Description: _____

 Tech Login ID.: _____
 Database Entry by: _____