

(please use the Oncology or Prenatal Cytogenetic 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.: _____
 Sex/Gender: Female Male Unknown

Requesting Physician Information

Name: _____ UPIN#: _____
 Location/Institution: _____
 Signature: _____
 Send Additional Reports To: _____

Clinical Indication or Reason for Cytogenetic Testing

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Trisomy 21 | <input type="checkbox"/> Mental retardation | <input type="checkbox"/> Turner syndrome | <input type="checkbox"/> Multiple miscarriage |
| <input type="checkbox"/> Trisomy 18 | <input type="checkbox"/> Developmental delay | <input type="checkbox"/> Klinefelter syndrome | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Trisomy 13 | <input type="checkbox"/> Dysmorphic features | <input type="checkbox"/> XYY syndrome | <input type="checkbox"/> Ambiguous genitalia |
| <input type="checkbox"/> Fetal demise | <input type="checkbox"/> Failure to thrive | <input type="checkbox"/> XXX syndrome | <input type="checkbox"/> M.C.A |
| <input type="checkbox"/> Family history of chromosome abnormality <i>(explain)</i> _____ | | | |
| <input type="checkbox"/> Other: _____ | | | |

Specimen Information

- Peripheral blood
 Skin P.O.C.
 Other - *Indicate Type:* _____
 Date Collected: _____
 Time Collected: _____

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

Conventional Chromosome Analyses
(Karyotyping)

- Routine/conventional chromosome study
 Other
Please Specify: _____
 Cell line build up for additional studies
Please Specify: _____

FISH Analyses

All requests for FISH analysis must include a routine chromosome study

- 7q11.23 - Williams syndrome
 15q11.2 - Angelman syndrome
 15q11.2 - Prader-Willi syndrome
 17p11.2 - Smith-Magenis syndrome
 17p13.3 - Miller-Dieker syndrome
 22q11.2 - DiGeorge/VCF syndromes
 Xp22.3 - Kallman Syndrome
 Xp22.3 - Steroid Sulfatase Deficiency
 Yp11.3 - SRY X/Y

Other : _____
(please inquire as to availability)

For Lab Use Only

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

Tech Login ID.: _____
 Database Entry by: _____

Standard 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: _____