



REGIONAL CYTOGENETICS LABORATORY REQUISITION

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PIN: _____ UNIT: _____ ROOM: _____
NAME: LAST _____ FIRST _____
ADDRESS: _____
SEX: _____ BIRTHDATE: YYYY/MM/DD _____ AGE: _____
OHC#: _____
PHYSICIAN: _____

1. TEST REQUESTED

- Chromosome Karyotype
- Cells for Dispatch to: _____
- FISH (Fluorescence in situ Hybridization) Study
for: _____
- Other: _____

2. SPECIMEN TYPE (label correctly)

- Blood
- Bone Marrow
- Amniotic Fluid gestational age: _____
- Chorionic Villus gestational age: _____
- Skin Biopsy (specify site): _____
- Products of Conception / Fetal Tissue
specify source: _____
- Stillbirth
- Lymph Node (source): _____
- Solid Tumour (source): _____
- Other: _____

3. CLINICAL INDICATIONS (specimen will not be processed without history)

- MSS (+) for (specify): _____
- ≥3.5 mm NT Measurement
- Down Syndrome
- Trisomy 13
- Trisomy 18
- Turner Syndrome or Amenorrhea
- Short Stature
- Klinefelter Syndrome
- Ambiguous Genitalia
- Developmental Delay with Dysmorphic Features
- Multiple Malformations
- Microdeletion Syndrome (specify): _____
- Infertility
- ≥3 Pregnancy Losses
- Family Study of: _____
- CML (Philadelphia chromosome)
- AML
- ALL
- CLL
- Myelodysplastic Syndrome
- Post Bone Marrow Transplant
Sex of Donor: Male Female
- Lymphoma (specify): _____
- Cancer (specify): _____
- Other: _____

FAILURE TO COMPLETE REQUISITION WILL RESULT IN DELAYS

Referring Physician: _____

Additional Copies: _____

Hospital / Lab: _____

Address: _____

Telephone: _____ Fax: _____

Date Specimen Collected: (YYYY/MM/DD) _____ Time: (HH/MM) _____

Date Specimen Sent: (YYYY/MM/DD) _____ Time: (HH/MM) _____

Requisition Completed by: _____