UPMC
LIFE CHANGING MEDICINE

UPMC CYTOGENETICS LABORATORY
Constitutional Cytogenetic Requisition

UPMC Magee-Womens Hospital
300 Halket Street, Rm. 1225
Pittsburgh, PA 15213
(412)641-5558 TEL (412)641-2255 FAX

PATIENT INFORMATION (*Please print or apply patient label):*	SPECIMEN (Check one)
Last Name: First: MI:	Date/Time of Collection:
Address:	○ Peripheral Blood ○ Cord Blood ○ Fetal Blood (PUBS)
City: State: Zip:	○ Amniotic Fluid* ○ CVS*
Phone #: DOB (mm/dd/yyyy):	○ Solid Tissue (list type):
Sex: ○ Male ○ Female ○ Ambiguous	○ Paraffin Section (list source):
Medical Record #: Account#:	*NOTE: Maternal Blood (purple top) should accompany all prenatal samples.*

REFERRING PHYSICIAN (*MUST BE COMPLETED*)

Ordering Provider: Address: Tel: Fax:	Additional Report To: Address: Tel: Fax:

Signature of Requesting Physician (REQUIRED):

Send Charges To: ○ Patient ○ Insurance (attach insurance info) ○ Institution (list):

CLINICAL DIAGNOSIS/PHYSICAL FINDINGS

ICD-10 Code(s):

○ Advanced Maternal Age	○ Developmental Delay	○ Intellectual Disability	○ Congenital Heart Defect
○ Elevated MSAFP	○ Inc. Trisomy 18 risk	○ Inc. Trisomy 21 risk	○ Spontaneous Abortion/Stillbirth
○ Hx. of ONTD (spina bifida/anenceph.)	○ Seizures	○ Autism	○ Encephalopathy
○ Multiple congenital anomalies	○ Infertility	○ Repeated Pregnancy Loss	

○ Ambiguous Genitalia: →
Previous Cytogenetic Analysis if performed: ○ XY ○ XX
○ Dysmorphic features (specify): →
○ Follow-up to previous study: → Test performed: Date:
○ Other:

FOR PRENATAL STUDIES

LMP:	Gravida: Para: SA: TA:	Diabetic? ○ No ○ Yes	
Ultrasound Date:	Gestational age:	Composite:	BPD:

Ultrasound Abnormalities: ○ No ○ Yes If yes, list:

TEST(S) REQUESTED (*MUST BE COMPLETED*)

○ **Chromosome Analysis (Karyotype)**	
○ **Amniotic Fluid AFP**	○ **Amniotic Fluid AchE**
○ **Fluorescence In Situ Hybridization (FISH) Studies**	
○ Prenatal Interphase Study (chroms. 13, 18, 21, X, Y)	○ R/O Duplication 15q11-q13
○ DiGeorge/VCF Syndrome (22q11)	○ R/O Trisomy/Triploidy (Paraffin Section)
○ Prader-Willi Syndrome/Angelman Syndrome (15q11q13)	○ R/O Trisomy (specify):
○ Suspected Familial Deletion/Duplication Syndrome (specify):	
○ Other(list):	
○ **180K SNP+CGH Combo Microarray Testing (Purple top tube required)**	
○ **180K X-HR (X chromosome high resolution) Microarray Testing (Purple top tube required)**	

LAB USE ONLY Accession #: Tech: Date Received: