CONSTITUTIONAL (BLOOD) TEST REQUISITION FORM

Cytogenetic Laboratories
Indiana University School of Medicine
975 W. Walnut, IB 350, Indianapolis, IN 46202
317/274-2243 (Office) 317/278-1616 (Fax)

Patient Laboratory Label

CAP#: 16789-30 **CLIA#: 15D0647198**

1) PHYSICIAN(S):

Ordering Physician: Kelley Faber, MS, CCRC
Address: MMGE HS 4007
City: Indianapolis State: IN Zip: 46202
Phone: 317-274-7360 Fax: _____

Primary Physician: Zoë Potter
Address: MMGE HS 4000H
City: Indianapolis State: IN Zip: 46202
Phone: 317-278-9086 Fax: _____

FOR LABORATORY USE ONLY:

Date Received: _____/_____/_____
Time Received: _____:_____am/pm
Received By: _____

Account 40-849-19
ABC-DS study

☐ BL

☐ CMA ☐ MO ☐ C-banding ☐ Q-banding ☐ NOR-staining

Handling Charge x _____ ☐ Handling **ONLY**

Lab Comment(s): Vacs: _____ green _____ purple; Other _____

2) PATIENT INFORMATION:

ABC-DS BDS ID: _____ Original volume drawn (1x4 mL NaHep tube): _____ mL

4) REFERRING DIAGNOSES *(lease check all that a l)*:

☐ Ambiguous Genitalia
☐ Autism Spectrum Disorder
☐ Congenital Heart Defect
☐ Developmental Delay
☒ Down Syndrome
☐ Dysmorphic Features
☐ Failure to Thrive
☐ Hypotonia
☐ Multiple Congenital Anomalies
☐ Recurrent Pregnancy Loss
☐ Seizures
☐ Short Stature
☒ Other ABC-DS Study
☒ ICD-10 Code: _____
☐ Family History of Chromosome Abnormality **(Please provide name, DOB, MRN)** _____

5) REQUESTED TESTING:

☒ Standard Chromosome Analysis/Karyotype
-- 1 Sodium Heparin Tube (Dark Green-top); 3 mL (infants), 7 mL (adults)

☐ Rapid Chromosome Analysis/Karyotype:
-- Preliminary result in 48-72 hours
-- 1 Sodium Heparin Tube (Dark Green-top); 3 mL (infants)

☐ Peripheral Blood or Skin Biopsy for Fanconi Anemia Breakage Study using DEB
-- 2 Sodium Heparin Tubes (Dark Green-top); 7-12 mL

☐ Standard Chromosome Analysis **with** Reflex to Microarray (CMA):
-- Reflexes if karyotype is normal.
*-- 1 EDTA Tube (Purple-top); **minimum** 1 mL*
-- 1 Sodium Heparin Tube (Dark Green-top); 3 mL (infants), 7 mL (adults)

☐ Fluorescence In Situ (FISH) Analysis *(Select Probe below)*
-- 1 Sodium Heparin Tube (Dark Green-top); 2 mL

☐ Aneuploidy FISH Full Panel (13, 18, 21, X/Y)
☐ Aneuploidy FISH 13/21 Only
☐ Aneuploidy FISH 18/X/Y Only
-- Results in 24-72 hours
*-- 1 Sodium Heparin Tube (Dark Green-top); 2 mL, **minimum** 1 mL*

☐ Constitutional Chromosomal Microarray (CMA) - Peripheral Blood is preferred.
Two tubes of blood are required:
-- 1 EDTA Tube (Purple-top); minimum 1 mL
*-- 1 Sodium Heparin Tube (Dark Green-top); **minimum** 1 mL*
Buccal Swabs are also accepted (contact lab for collection kit).

☐ Parent/Family Member Studies as Follow-up to CMA
(Test performed based on recommendations in proband's CMA report.)
--1 Sodium Heparin Tube (Dark Green-top); 2 mL
Please provide previous patient information (Name, MRN, DOB)
_____

6) MICRODELETION FISH ANALYSIS REQUESTED:

☐ Angelman
☐ Cri-Du Chat
☐ DiGeorge (VCFS)
☐ Kallman
☐ Miller-Dieker
☐ Prader-Willi
☐ Smith-Magenis
☐ SRY
☐ STS
☒ Williams
☒ Wolf-Hirschhorn