# KARYOTYPE AND MICROARRAY REQUEST FORM

Cytogenetics Laboratory
UNC Hospitals; McLendon Laboratories
and Department of Pediatrics
Rm 1071, 1st Floor Memorial Hospital
101 Manning Drive, CB# 7487
Chapel Hill, NC 27514
Phone: (984) 974-1790 Fax: (984) 974-1666

Attending physician requesting study:

Office address:

Copies of report should be sent to:

Phone Number:
Pager #:
Fax #:

Medical Record #:
Patient Name:

Date of Birth: Sex:

Social Security #:

Address:
City, State, Zip

Home telephone #:

Date: Specimen Type:
Time:

**If patient is a Baby Boy/Girl, add the following information:

Mother's name:

DOB:

**For lab use only**
**Lab No:** **Date Rec'd:**

## CLINICAL DATA:

1. Is this patient infectious? ☐ No ☐ Yes; If yes, what organism? _____
2. Is this a RUSH request? ☐ No ☐ Yes; If yes, please specify (critically ill newborn, surgery/treatment, pending pregnancy): _____
3. **Is this patient or a close relative pregnant? ☐ No ☐ Yes** If yes, please indicate relationship of pregnant person to patient (mother, sister, etc.) **and gestational age of pregnancy:**

   _____
4. If you suspect a specific chromosome abnormality, please indicate which one: _____
5. Indication for study: **(Describe clinical features/pertinent family history, etc)**

   ☐ Developmental delay/mental retardation
   ☐ Dysmorphic features
   ☐ Autism
   ☐ Seizure disorder
   ☐ Short stature
   ☐ Suspect trisomy for chr_____
   ☐ Major birth defect (please specify) _____
   ☐ Multiple congenital anomalies (please specify)_____
   ☐ Parental follow-up for (please give proband name and lab #): _____
   ☐ Other (please specify) _____

**REQUEST FOR KARYOTYPE AND/OR MICROARRAY STUDIES (please choose one):**

☐ Karyotype Only
☐ Microarray with Karyotype (**20 cell analysis**)
☐ Microarray with Karyotype (**5 cell analysis**)
☐ Microarray Only (**Karyotype Previously Performed**)
Previous karyotype result: _____
Where/when performed: _____

**REQUEST FOR FLUORESCENCE IN SITU HYBRIDIZATION (FISH) STUDIES:**

☐ Angelman/Prader-Willi duplication
☐ Angelman (**hold pellet** methylation test pending)
☐ Angelman (deletion)
☐ Prader-Willi deletion
☐ Prader-Willi (**hold pellet** methylation test pending)
☐ DiGeorge/VCF
☐ Kallmann
☐ Miller-Dieker
☐ Smith-Magenis
☐ SRY (**S**ex determining **R**egion on **Y**)
☐ Steroid Sulfatase Deficiency
☐ Sotos
☐ Subtelomere assay (ToTelVysion)
☐ Williams
☐ X/Y Centromere
☐ Other

Please note: Submission of a sample to the Cytogenetics Laboratory accompanied by this form will be considered authorization to perform routine cytogenetic testing including tissue culture, counting additional cells, special staining, and fluorescence in situ hybridization (FISH) as deemed appropriate by the laboratory directors.

Signature: _____ Date: _____