

<p><u>KARYOTYPE AND MICROARRAY REQUEST FORM</u> 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</p>	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:
Attending physician requesting study: Office address: Copies of report should be sent to: Phone Number: Pager #: Fax #:	
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)**

<input type="checkbox"/> Developmental delay/mental retardation	<input type="checkbox"/> Seizure disorder
<input type="checkbox"/> Dysmorphic features	<input type="checkbox"/> Short stature
<input type="checkbox"/> Autism	<input type="checkbox"/> Suspect trisomy for chr _____
<input type="checkbox"/> Major birth defect (please specify) _____	
<input type="checkbox"/> Multiple congenital anomalies (please specify) _____	
<input type="checkbox"/> Parental follow-up for (please give proband name and lab #): _____	
<input type="checkbox"/> Other (please specify) _____	

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

- | | |
|--|--|
| <input type="checkbox"/> Karyotype Only | <input type="checkbox"/> Microarray Only (Karyotype Previously Performed) |
| <input type="checkbox"/> Microarray with Karyotype (20 cell analysis) | Previous karyotype result: _____ |
| <input type="checkbox"/> Microarray with Karyotype (5 cell analysis) | Where/when performed: _____ |

REQUEST FOR FLUORESCENCE IN SITU HYBRIDIZATION (FISH) STUDIES:

- | | |
|--|---|
| <input type="checkbox"/> Angelman/Prader-Willi duplication | <input type="checkbox"/> Smith-Magenis |
| <input type="checkbox"/> Angelman (hold pellet methylation test pending) | <input type="checkbox"/> SRY (Sex determining Region on Y) |
| <input type="checkbox"/> Angelman (deletion) | <input type="checkbox"/> Steroid Sulfatase Deficiency |
| <input type="checkbox"/> Prader-Willi deletion | <input type="checkbox"/> Sotos |
| <input type="checkbox"/> Prader-Willi (hold pellet methylation test pending) | <input type="checkbox"/> Subtelomere assay (ToTelVysion) |
| <input type="checkbox"/> DiGeorge/VCF | <input type="checkbox"/> Williams |
| <input type="checkbox"/> Kallmann | <input type="checkbox"/> X/Y Centromere |
| <input type="checkbox"/> Miller-Dieker | <input type="checkbox"/> 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: _____