PRENATAL CYTOGENETICS REQUEST FORM

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

Medical Record #:

Patient Name:

Date of Birth:

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

PATIENT INFORMATION

PT_____ DOB: _____ LMP:_____

HUSB/PART_____ DOB: _____ G___P___AB_____

Mat Race_____ Genetic Counselor:_____

REFERRING PHYSICIAN

Name_____ Practice Name:_____

City_____ Phone:_____ FAX: _____ Pager:_____

Indications for Amnio/CVS

- ☐ IUFD
- ☐ Increased Maternal Age
- ☐ Positive Screen for
  ☐ DS ☐ ONTD ☐ SLO ☐ Tri 18
- ☐ Abnormal Ultrasound _____
  _____
- ☐ FM HX of _____
- ☐ Other _____

Prenatal Tests Requested

Chromosome analysis will be done on all samples unless otherwise indicated. AF-AFP will be completed on pregnancies between 13-0/7 weeks and 23-6/7 weeks of gestation unless otherwise indicated.

Routine Chromosome Analysis: ☐Yes ☐No
Routine AF-AFP: ☐Yes ☐No

- ☐ Direct CVS result
- ☐ Prenatal Interphase FISH (13,18,21,X,Y)
- ☐ DiGeorge/VCF (22q)
- ☐ Additional Testing: _____
- ☐ Ancillary Tests Pending _____ (Save Cells)

PROCEDURE AND SAMPLE INFORMATION

DATE OF ULTRASOUND _____

CLINIC: ☐ UNC ☐ REX ☐ L&D ☐ OTHER _____ GEST AGE BY U/S_____

PROCEDURE DATE:_____ PERFORMED BY DR. _____ DR. CODE: _____

FETAL ULTRASOUNDABNORMALITIES_____

** FETAL SEX BY ULTRASOUND IF REQUESTING INTERPHASE FISH: _____

IS SPECIMEN AMNIOTIC FLUID? ☐ YES ☐ NO; IF NO, SPECIFY SAMPLE TYPE_____

SAMPLE APPEARANCE: ☐ CLEAR ☐ BLOODY ☐ OTHER_____

ADDITIONAL COMMENTS:

CALLED TO: _____
(NAME/DATE/TIME)

Bottom copy: Physician's Copy Top two copies: Cytogenetics Laboratory

Lab Use Only
AFP: _____
AChE Pending ☐
Final AChE: _____
Inhibitor: _____
Sent to FBR: _____