THE UNIVERSITY OF OKLAHOMA
HEALTH SCIENCES CENTER

Genetics Laboratory Department of Pediatrics
Cytogenetics Requisition

Patient Sticker Here

Basic Sciences & Education Bldg
941 Stanton L. Young Blvd. 224
Oklahoma City, OK 73104
Phone: 405-271-3589
Fax: 405-271-7117
After hours phone: 405-496-9514
www.genetics.ouhsc.edu

Please have all specimens delivered to the Core Laboratory of OU Medical Center located in the Everett Tower basement

REFERRING PHYSICIAN/FACILITY

Requesting Physician_____

Physician's Phone_(____)_____ Cell/Pager_(___)_____

Clinic/Hospital DLO at Integris Baptist Hospital

Phone (405) 949-6829 Fax (405)945-5445

Preliminary and final reports faxed to the referring physician or facility please provide appropriate fax number_(____)_____

Genetic Counselor_____ Phone_(____)_____

Cell/Pager_(____)_____

PATIENT AND BILLING INFORMATION

Patient Name (last,first,m.)_____

DOB_____ SSN_____ MRN_____

Sex: Male Female Ambiguous □ Inpatient □ Outpatient

Patient's Address_____

State_____ Zip Code_____ Phone Number_(____)_____

'STAT' specimen to pass through DLO

SPECIMEN/CLINICAL INFORMATION

Reason for study (clinical indications or ICD-9 codes)_____

_____Date Collected_____ Time_____ Initials_____

SPECIMEN REQUIREMENTS

□ **Peripheral Blood** □ **Cord Blood** □ **Pellet** previous lab # _____
3-5 cc in large sodium heparin tube (dark green top), mix well. Keep specimen at room temperature or cooler, do not freeze. No additional blood needed for FISH

□ **Amniotic Fluid** □ **CVS** □ **Fetal Urine**
DO NOT TRANSPORT SPECIMENS IN SYRINGES!
Collect 15-20 cc and transfer to sterile centrifuge tubes. For FISH studies an additional 5 cc of fluid is required. Keep specimen cool but do not freeze.
Gestational age by: ultrasound_____ or LMP_____
Gravida__ __ Para__ __ __ __

ACHE	yes	no	**Alpha fetoprotein**	yes	no

□ **Bone Marrow** □ **Leukemic Blood/Peripheral Blood for neoplastic study**
3-5 cc in heparinized syringe, large sodium heparin tube (dark green top) or transport medium. Fresh sample keep at room temperature, do not freeze. No additional specimen is needed for FISH studies. **Recent WBC**_____
Chemotherapy yes no □ Pre-transplant □ Post-transplant □ Protocol patient

□ **Skin Biopsy** □ **Products of Conception** □ **Placenta** □ **Fetal Tissue**
□ **Solid Tumor** 2-3 cc/1-2cm2 in transport media or sterile normal saline. Do not use formalin and do not use a fixative. Observe sterile technique. Keep cool, do not freeze
□ **Unstained Slides (FISH testing only)**
□ **Buccal swab (FISH testing only)** Collect 2 specimens w/nylon brushes. Keep fresh sample at room temperature.

TEST INFORMATION

Test Type
□ **Karyotype** (routine chromosome analysis)

□ **Karyotype and FISH** Select a FISH probe

□ **FISH only** _____ Previous chromosome studies have been done. Provide a copy of these results if performed at another lab.

□ **Culture only** _____

FISH Probes
□ Trisomy of _____
□ Screen for trisomies of 13, 18, 21, X and Y

□ Angelman syndrome	□ CHARGE syndrome
□ DiGeorge syndrome 22q11.2	□ DiGeorge 10p14
□ Klinefelter syndrome	□ Prader-Willi syndrome
□ Sex chromosomes	□ Sotos syndrome
□ Subtelomeres	□ Turner syndrome
□ Williams syndrome	□ Other_____

FISH Probes Oncology

□ t(12;21) ALL	□ t(8;21) AML M2
□ t(15;17) AML M3	□ inv(16) AML M4
□ t(9;22) CML	□ t(11;14) Mantle cell lymphoma
□ del(5) or monosomy 5 MDS	□ del(7) or monosomy 7 MDS
□ Ewings sarcoma	□ t(12;16) FUS/CHOP

ADDITIONAL REPORT

Physician/Facility_____

Phone_(___)_____ Fax_(___)_____

Address_____

_____

□ OU Medical Center Clinical Laboratory Referral

GENETICS LABORATORY USE ONLY

Laboratory Number_____

Date & Time of Pick-Up/Delivery_____

Location_____

Initials_____ Check-in_____

Checked Database_____ Entered in Database_____

Additional Specimen(s) sent for this patient_____

Previous Lab Number_____