UROVYSION REQUISITION FORM
CYTOGENETICS

Please provide all pertinent information **UCLA Cytogenetics Lab accession number:** _____

PATIENT INFORMATION	SPECIMEN INFORMATION
ID #	**Collection Date:** **Time:**
Name: Last First MI	**Collected By:**
	Date Received by Cytogenetics Lab: Time: Tech**:**
Date of Birth: **Sex: M F**	**TYPE OF SPECIMEN:** ☐ Voided Urine ☐ Other _____ **CYTOLOGY REPORT:** ☐ Normal ☐ Abnormal ☐ Atypical
Ethnicity	**Location/Clinic:**
	Volume Recv'd: Appearance**:**

REFERRAL PATIENTS: PLEASE ATTACH PATIENT INSURANCE INFORMATION TO THIS FORM

REPORTING INFORMATION:

Ordering Physician: _____UPIN # ___ ___ ___ ___ ___Phone/Pager: _____ FAX:_____

Send copy to: _____ Address: _____

Genetic Counselor_____ Phone #: _____ FAX#: _____

Notice to ordering physicians: Medical necessity for the test(s) requested must be indicated by ICD-9 codes. ICD-9: _____

Test Requested:

FISH STUDIES

☐ Uro Vysion

☐ Other _____

CLINICAL INDICATIONS / DIAGNOSIS FOR FISH STUDY: _____

_____

☐ **ICD-9 Code:** _____

SPECIMEN COLLECTION INSTRUCTIONS:

1. Collect voided urine specimen before Cystoscopy. At least 30mL are required.
2. Write name of patient and date on label of collection cup containing the preservative.
3. Invert/mix urine specimen several times before adding 30mLs of urine to the methanol (preservative) cup.
4. Refrigerate specimen until courier picks up.
5. Send specimen to Cytogenetics Lab as soon as possible.

P.Nagesh Rao, PhD., FACMG
Chief, Clinical and Molecular Cytogenetics
UCLA HEALTH SYSTEM/ CLINICAL LABORATORIES

SEND ALL SPECIMENS TO THIS ADDRESS
UCLA Cytogenetics Center
1000 Veteran Avenue (Rehabilitation Center) Room: 2-226
Los Angeles, CA 90024 Phone: (310) 794-1287
Fax: (310) 794-4139