UCLA Health System

MRN:
Patient Name:

(Patient Label)

PRENATAL CLINICAL CYTOGENETICS
REQUISITION FORM

Procedure: FORM 13.0
Effective: 10/01/19

Please provide all pertinent information

PATIENT INFORMATION	**SPECIMEN INFORMATION**
MRN #	**Collection Date:** **Time:**
Name: Last First MI	**Collected By:**
	(Cytogenetics lab use only) Date Received by Lab: Time: Tech**:**
Date of Birth: **Sex: M F**	**TYPE OF SPECIMEN:** ☐ Amniotic Fluid ☐ Chorionic Villus ☐ PUBS ☐ Products of Conception ☐ Other ☐ Blood
Ethnicity	AF VOLUME SENT:________ML # OF TUBES: _____ APPEARANCE:

REFERRAL PATIENTS: PLEASE PROVIDE COMPLETE BILLING INFORMATION –SEE REVERSE SIDE

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-10 codes. ICD-10: ______

OBSTETRIC / PATIENT INFORMATION:

G_____P_____A_____ [SAB____TAB____]

Gestational Age: Date of LMP: ____________ Date of Ultrasound: ____________ by BPD:___________

CLINICAL INDICATIONS / DIAGNOSIS FOR CHROMOSOMAL STUDIES:

☐ Advanced Maternal Age ___________ years ☐ Expanded AFP ☐ Trisomy 13/18 risk ☐ Trisomy 21 risk ☐ NTD
☐ Abnormal Ultrasound (Specify) ____
☐ Family history of genetic/chromosome disorder: __________________________________ ☐ Other**:** _____________________

TEST REQUESTED: ***INCLUDES PATHOLOGIST'S INTERPRETATION AND CONSULTATION***

☐ **Chromosome Analysis**
☐ **Chromosome & FISH Analysis**: Please select FISH probes below:
  ☐ **Aneuploidy (X/Y/13/18/21)** ☐ **deletion 22q11.2** ☐ **STS** ☐ **Other** (consult cytogenetics lab) __________________
☐ **Chromosome & Microarray* Analysis** *Please submit separate requisition for Microarray testing, requires maternal blood for MCC
  ☐ **Add rapid Aneuploidy FISH (X/Y/13/18/21)**
☐ **Culture and Save (**cultures saved up to 6 weeks from sample receipt)
  ☐ **for future Prenatal Microarray*** ☐ **Other** ______________________
  ☐ **for future Prenatal Exome***
  *Please submit separate orders/requisition for Microarray or Exome testing (additional requirements for parental specimens)

Send out Testing (Please provide the completed send out lab requisition form)
  ☐ **AF-AFP and ACHE** ☐ **Other Send out** ____
  ☐ **direct specimen** ☐ **cultured cells** (indicate amount) _________________

SPECIMEN COLLECTION: KEEP ALL SAMPLES AT ROOM TEMPERATURE

Amniotic Fluid: (Discard the first 2 mL of fluid) GA of >15 weeks: >20 mL of fluid **PUBS**: 1-2 mL in a sodium heparin tube
Chorionic Villus Sampling (CVS): minimum 20 mg **Parental blood**: 2 mL in sodium heparin tube

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UCLA HEALTH SYSTEM/ CLINICAL LABORATORIES

SEND ALL SPECIMENS TO:
200 Medical Plaza, Suite 145
Los Angeles, CA 90095
(310) 267-8100 opt 1