Cytogenetic Laboratory
Royal Columbian Hospital Referring Hospital _____

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CYTOGENETIC PRENATAL DIAGNOSIS REQUISITION

Additional copies to : Name:_____

Address: _____

Phone Number: _____

Cytogenetics Number

G:_____ T:_____ A:_____ L:_____ LMP:_____

Indications (please mark with X and specify when requested)

1. Advanced Maternal Age
   (Singleton ≥ 35 yrs; twins ≥ 32 yrs; triplets ≥ 28 yrs at EDC) ☐
2. Positive maternal serum multiple screen (specify) ☐ _____
3. Previous liveborn/stillborn child with a chromosomal abnormality (except monosomy X) ☐ _____
4. Parent with potentially transmissible chromosomal rearrangement ☐ _____
5. Fetal anomaly detected on prenatal ultrasound indicative of a risk of a fetal chromosomal abnormality ≥ 0.5% ☐ _____
6. Follow up after CVS ☐ _____
7. Increased risk of chromosomal breakage syndrome in the fetus ☐
8. Culture for DNA or biochemical studies only ☐

   Preliminary result by fluorescence in situ hybridization ☐

Specimen: **Amniotic Fluid:** tube#1 _____ mL tube#2 _____ mL **CVS:**_____mg **Fetal Blood:**_____

Date Taken: _____ **Time:** _____ **Procuring Physician:** _____

LABORATORY USE ONLY

Date Received:_____ Time: _____
Date Completed: _____
Diagnosis: _____ # cells: _____ BLR: _____
Units: _____ Extra Cells: _____

Date Done:_____ TAT: ___ Date Reported: _____
Faxed/Phoned to : _____
Signature: _____
C-bdg: _____ Q-bdg: _____ FISH: _____