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Reset Form

Cytogenetics Accession Number _____

MOLECULAR CYTOGENETICS

Embryofetal / Placental Tissue Samples - Chromosome Analysis

Royal Columbian Hospital Phone (604) 520-4484
330 E Columbia St. Fax (604) 520-4149
New Westminster, BC V3L 3W7

Patient name: _____
Last First

Date of Birth: _____ Sex: ☐ M ☐ F
DD/MM/YYYY

PHN: _____

Insurance: MSP
Self pay, Out of Prov., WCB, RCMP, Veterans, and Refugee etc.

Ordering Physician: _____

Physician MSP Number: _____

Patient Address: _____ City: _____

Province/State: _____ Country: _____ Postal Code: _____ Phone: _____

Additional copies to: _____ _____ _____
Name & MSP number Name & MSP number Name & MSP number

1. **ALL Patient Demographics must be printed legibly and completed in full.**
2. **Reason for analysis is essential, failure to provide this information may result in a delayed report.**
3. **All Non Canadian Residents must sign a FHA waiver form. The signed and witnessed form must be attached to the requisition when specimen submitted.**
   Molecular Cytogenetics Specimen Collection and Submission

Collection date: _____ Collection time: _____ Collected by: _____
DD/MM/YYYY HH:MM

Specimen Submitted: ☐ Amnion ☐ Chorion ☐ Other _____

Clinical Information:

Gravida _____ Para _____ Abortion _____ Loss _____ Gestation (weeks) _____

Physician signature or stamp: _____

LAB USE ONLY:

Date received: _____ Date incubated: _____