Molecular Cytogenetics
Prenatal Diagnosis Chromosome and Fluorescence in situ Hybridization (FISH) Requisition

Royal Columbian Hospital
Molecular Cytogenetics Laboratory Rm. B180
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Laboratory Use Only
Accessioning Number
Received Date

Patient Information		Physician Information
Last Name	First Name	Ordering Physician (Name and Billing #)
Date of Birth (DD/MM/YY)	PHN	Additional Reports to: (Name and Billing #)
Gender: M ☐ F ☐	Patient Telephone #	
Patient Address		Medical Genetics #:_____

Note: All Non-Canadian Residents must submit a signed and witnessed FHA waiver form. Please attach waiver to the lab requisition.
Further Collection and Waiver Form: Molecular Cytogenetics Specimen Collection and Submission

Amniotic Fluid

Chromosome Analysis: Tube #1_____mL Tube #2_____mL FISH Analysis: Tube #3_____mL

Procuring Physician:_____ Collection Time:_____ Date:_____

Clinical History and Indication:

Please Specify: (**Note**: Failure to provide this information will result in delay of testing)

Gravida _____ **Para** _____ **Abortions** _____ **Loss** _____ **Current Gestational Age** _____

Reasons for Analysis: (check all that apply)

- ☐ Advanced Maternal Age ≥ 40 years
- ☐ Advance Maternal age 35-39 years, no prior screening, singleton ≥ 21 weeks gestation
- ☐ Advance Maternal age 35-39 years, no prior screening, multiple gestation
- ☐ Positive maternal serum multiple screening (specify):_____
- ☐ Previous liveborn / stillborn child with a chromosome abnormality (except for monosomy X) (specify):
  _____
- ☐ Parents with potentially transmissible chromosome rearrangements (specify):
  _____
- ☐ Fetal anomaly detected on prenatal ultrasound indicative of a risk of a fetal chromosome abnormality ≥ 0.05% (specify):
  _____
- ☐ Pregnancy following in vitro fertilization with intracytoplasmic sperm injection (IVF with ICSI)
- ☐ Increase risk of chromosomal breakage syndrome in the fetus
- ☐ Follow up after CVS_____

Test Request:

☐ Fluorescence in situ Hybridization (FISH) ☐ Karyotype ☐ Culture for DNA

Ordering Physician Signature (Required) Date (DD/MM/YY)

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Tube #1_____mL Pellet:_____ Tube #2_____mL Pellet:_____ Tube #3_____mL Pellet:_____

Comments:

Date Incubated:_____