

MOLECULAR CYTOGENETICS
Peripheral Blood Chromosome
Analysis and Fluorescence
in situ Hybridization (FISH)

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

Ordering Physician: _____
Name MSP number

Medical Genetics # _____

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

Reason for Analysis: *(check all that apply)*

- Developmental / speech / intellectual delay *(specify)*: _____
- Seizures *(specify)*: _____
- Behavioural Abnormalities; including autism *(specify)*: _____
- Congenital Abnormalities
 - Klinefelter Syndrome
 - Down Syndrome
 - X-linked mental retardation
 - Turner Syndrome
- Growth Abnormalities *(specify)*: _____
- Specific cranio-facial features / malformations *(specify)*: _____
- Other *(specify)*: _____
- Recurrent Spontaneous Abortions / Infertility G: ____ P: ____ A: ____ L: ____ Partner to: _____

Test Requested:

- Karyotype Fluorescence in situ Hybridization (FISH) Microarray follow up

Physician signature or stamp: _____

LAB USE ONLY:

Date received: _____ Date incubated: _____ Specimen sent to: _____

Specimen Type: Sodium Heparin _____ tubes, volume _____ mL EDTA _____ tubes, volume _____ mL