fraserhealth Better health. Best in health care.

Reset Form

Cytogenetics Accession Number

_____

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: _____
Name MSP number

Medical Genetics # _____

MOLECULAR CYTOGENETICS

Prenatal Diagnosis 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 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

Procuring physician: _____ Collection date: _____ Collection time: _____
Name & MSP number DD/MMM/YYYY HH:MM

G: _____ P: _____ A: _____ L: _____ Current GA: _____

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

- ☐ Advanced Maternal age ≥ 40 years
- ☐ Advanced Maternal age 35-39 years, no prior screening, singleton ≥ 21 weeks gestation
- ☐ Advanced Maternal age 35-39 years, no prior screening, multiple gestation
- ☐ Positive maternal serum multiple screen (*specify*): _____
- ☐ Previous liveborn/stillborn child with a chromosome abnormality (except monosomy X) (*specify*): _____
- ☐ Parents with potentially transmissible chromosome rearrangement (*specify*): _____
- ☐ Fetal anomaly detected on prenatal ultrasound indicative of a risk of a fetal chromosome abnormality ≥ 0.5% (*specify*): _____
- ☐ Pregnancy following in vitro fertilization w/ intracytoplasmic sperm injection (IVF with ICSI)
- ☐ Increase risk of chromosomal breakage syndrome in the fetus
- ☐ Follow up after CVS (*specify*): _____

Test Requested: ☐ Karyotype ☐ Fluorescence in situ Hybridization (FISH)
☐ Culture for DNA biochemical studies only

Physician signature or stamp: _____

LAB USE ONLY:

Date received: _____ Date incubated: _____

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