Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

FORM# 0000-9000

GCL CYTOGENETICS

PATIENT INFORMATION (YELLOW AREAS MUST BE FILLED IN)

PATIENT LAST NAME	FIRST NAME	MI	PATIENT ID	DATE OF BIRTH	SEX	FASTING
					M F	YES NO

MAILING ADDRESS				ORDERING PHYSICIAN (FULL NAME	COMMENTS OR ADDITIONAL COPY OF REPORT T
CITY	STATE	ZIP	PATIENT PHONE		

SOCIAL SECURITY # PATIENT ONLY	– –	DATE COLLECTED	TIME COLLECTED AM PM	COLLECTED BY

WHEN MEDICARE PAYMENT WILL BE SOUGHT, ONLY TESTS WHICH ARE MEDICALLY NECESSARY SHOULD BE ORDERED.

BILL TO

☐ PHYSICIAN/PROVIDER ☐ PATIENT RESPONSIBLE PARTY (ONLY IF PATIENT IS A MINOR)

SEE ATTACHED COPY OF CARD

☐ MEDICARE ☐ MEDICAID (NON SALUD)

MEMBER # ON INSURANCE CARD: _____

☐ PHP ☐ BCBS ☐ SALUD (Indicate Plan) ☐ OTHER _____

INSURANCE ADDRESS: _____

PLAN NAME: _____ MEMBER ID NUMBER: _____

GROUP NUMBER: _____ EMPLOYER OF PRIMARY CARDHOLDER: _____

CALL Phone ( ) **STAT** Specify STAT TESTS: **Note:** Only critical values will be called

Diagnosis / Indications for Chromosome Testing: _____

Comments: _____

☐ Has a genetic consent form been signed by the patient?

☐ Have previous cytogenetics been done?

TESTS REQUESTED

Lab Use Only ☐ **GYTGEN** _____

INDIVIDUAL TESTS	Dx CODE	INDIVIDUAL TESTS	Dx CODE

Amniotic Fluid

Gestational Age _____

- ☐ Chromosome Analysis _____
- ☐ AFP (Alphafetoprotein) _____
- ☐ AchE (Acetylcholinesterase) _____
- ☐ Prenatal Aneuploid Test (P.A.T.) (FISH for 13, 18, 21, X and Y) _____

Chorionic Villi

- ☐ Chromosome Analysis _____

Peripheral Blood (Sodium Heparin Tube)

- ☐ Chromosome Analysis _____
- ☐ High Resolution Study _____

POC - Products of Conception

- ☐ Chromosome Analysis _____

Other

- ☐ _____

Skin Biopsy

- ☐ Chromosome Analysis, Solid Tissue _____
- ☐ Tissue Culture Only _____

Oncology Testing

- ☐ Chromosome Analysis, Blood _____
  WBC count: _____ % Blasts: _____
- ☐ Chromosome Analysis, Bone marrow _____
- ☐ Chromosome Analysis, Solid Tumor _____
  Tumor type: _____

Fluorescence in Situ Hybridization (FISH)

- ☐ CLL
- ☐ Myelodysplasia
- ☐ Myeloma
- ☐ Burkett t(8;14)
- ☐ 11q23 (MILL ge
- ☐ X,Y
- ☐ BCR-ABL1 t(9;2
- ☐ t(11;14) Mantle
- ☐ t(14;18) Follicula
- ☐ t(12;21) TEL/AM
- ☐ t(8;21) AML
- ☐ inv16 AML
- ☐ t(15;17) AML
- ☐ DiGeorge
- ☐ Smith-Magenis
- ☐ Prader-Willi
- ☐ Cri-du-Chat
- ☐ Williams
- ☐ Miller Dieker
- ☐ Trisomy: 13, 18 or 21
- ☐ Other: specify _____

☐ **48 HR TEST DELAY**

ADDITIONAL REPORTS TO	SHIP TO ADDRESS
Name: _____	TriCore Reference Laboratories
Address: _____	Att: Cytogenetics
City: _____	1001 Woodward Place NE
State/Zip: _____	Albuquerque, NM 87102
Fax: _____	**Phone:** (505) 938-8430
	Fax: (505) 938-8432
	Send Sample With Requisition (DO NOT SEPARATE)