

<b>KARYOTYPE AND MICROARRAY REQUEST FORM</b> Cytogenetics Laboratory UNC Hospitals; McLendon Laboratories and Department of Pediatrics Rm 1071, 1 <sup>st</sup> Floor Memorial Hospital 101 Manning Drive, CB# 7487 Chapel Hill, NC 27514 Phone: (919) 966-1595 Fax: (919) 966-1411	Medical Record #: Patient Name:  Date of Birth: <span style="float: right;">Sex:</span>  Social Security #:  Address: City, State, Zip  Home telephone #:				
Attending physician requesting study:  Office address:  Copies of report should be sent to:  Phone Number: Pager #: Fax #:	Date: <span style="float: right;">Specimen Type:</span> Time: **If patient is a Baby Boy/Girl, add the following information:  Mother's name:  DOB:				
<table border="1" style="width: 100%;"> <tr> <td style="text-align: center;"><b>For lab use only</b></td> <td style="text-align: center;"><b>Date Rec'd:</b></td> </tr> <tr> <td style="text-align: center;"><b>Lab No:</b></td> <td></td> </tr> </table>		<b>For lab use only</b>	<b>Date Rec'd:</b>	<b>Lab No:</b>	
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**CLINICAL DATA:**

1. Is this patient infectious?  No  Yes; If yes, what organism? \_\_\_\_\_
2. Is this a RUSH request?  No  Yes; If yes, please specify (critically ill newborn, surgery/treatment, pending pregnancy): \_\_\_\_\_
3. **Is this patient or a close relative pregnant?**  No  Yes If yes, please indicate relationship of pregnant person to patient (mother, sister, etc.) **and gestational age of pregnancy:** \_\_\_\_\_
4. If you suspect a specific chromosome abnormality, please indicate which one: \_\_\_\_\_
5. Indication for study: **(Describe clinical features/pertinent family history, etc)**
  - Developmental delay/mental retardation  Seizure disorder
  - Dysmorphic features  Short stature
  - Autism  Suspect trisomy for chr\_\_\_\_\_
  - Major birth defect (please specify) \_\_\_\_\_
  - Multiple congenital anomalies (please specify) \_\_\_\_\_
  - Parental follow-up for (please give proband name and lab #): \_\_\_\_\_
  - Other (please specify) \_\_\_\_\_

**REQUEST FOR KARYOTYPE (please choose one):**

- Karyotype and special stains, extra counts or FISH studies as deemed appropriate  Karyotype only

**REQUEST FOR MICROARRAY STUDIES (please choose one):**

- Karyotype and Microarray  Karyotype has been performed; proceed with microarray only

Previous karyotype (result): \_\_\_\_\_ Where/when was it done? \_\_\_\_\_

**REQUEST FOR FLUORESCENCE IN SITU HYBRIDIZATION (FISH) STUDIES:**

- |  |   |
|--|---|
| <input type="checkbox"/> Angelman/Prader-Willi duplication                           | <input type="checkbox"/> Smith-Magenis                              |
| <input type="checkbox"/> Angelman ( <b>hold pellet</b> methylation test pending)     | <input type="checkbox"/> SRY ( <b>Sex determining Region on Y</b> ) |
| <input type="checkbox"/> Angelman (deletion)   | <input type="checkbox"/> Steroid Sulfatase Deficiency               |
| <input type="checkbox"/> Prader-Willi deletion                                       | <input type="checkbox"/> Sotos                                      |
| <input type="checkbox"/> Prader-Willi ( <b>hold pellet</b> methylation test pending) | <input type="checkbox"/> Subtelomere assay (ToTelVysion)            |
| <input type="checkbox"/> DiGeorge/VCF  | <input type="checkbox"/> Williams                                   |
| <input type="checkbox"/> Kallmann  | <input type="checkbox"/> Other _____                                |
| <input type="checkbox"/> Miller-Dieker   |   |