


Cytogenetics Lab Accession #		 BRIGHAM AND WOMEN'S HOSPITAL		CAMD		Requisition Form	
Patient Name(1)		LAB I.D./M.R.N./S.S.N.				Patient Information (Card)	
Address		Group Number					
City, State Zip		Certificate Number					
Patient Tel #		Employer/Guarantor Tel #		Employer/Guarantor Address			
Date of Birth (Req.)		Male Female				Outside Lab Control Number	

Referring Physician Information							
Referring Physician (1) First Name Last Name			Physician Location (1)		Send Duplicate Reports To:		Written By: (Sig. Req.)
? Stat	Date/Time Taken		BICS ID #	UPIN #	ICD9 Code(s) (Required)(1)		
Ref. Physician e-mail			Ref. Physician Tel./Pager #(1)		Ref. Physician Fax #(1)		

Specimen Type(1)	Pregnancy Data	Prenatal Indications(1)	Cancer Indications(1)	Cancer Stage	Therapy History
Amniotic Fluid Chorionic Villi Peripheral Blood Leukemic Blood Sodium Heparin (Green Top) Tube Bone Marrow Tissue Tumor Other (Describe)	G _____ P _____ SAB _____ TAB _____ Gestational Age Does patient wish to know sex of fetus? YES NO	Abnormal Maternal Screen Increased Risk of NTD Increased Risk of Trisomy Advanced Maternal Age Abnormal Ultrasound Specify _____ Fam. Hx NTD Fam. Hx Chrom. Abn Multiple SABs Maternal Anxiety Other _____	ALL AML CLL CML NHL MDS other NOTE: indication may determine test protocol WBC=	LEUKEMIA Untreated Partial Remission Remission Advanced Relapsed Not Stated TUMOR Primary Metastasis Recurrent	Chemotherapy Radiation Hormonal Immunotherapy Surgery S/P BMT Sex of BM Donor Male Female

INDICATION (1)

NOTE: Specimen type, indication and WBC may determine test protocol

Note: All Procedures Include Professional Interpretation unless otherwise requested. No Professional interpretation
 Reflex or confirmatory testing will be performed according to policy and procedure unless otherwise requested. No reflex tests . Confirm with MD

TESTS REQUESTED	SPECIAL or SEND OUT (2)	SEND OUT Information
<input type="checkbox"/> Chromosome Analysis (2) <input type="checkbox"/> Alpha-Feto Protein <input type="checkbox"/> FISH <input type="checkbox"/> Other tests _____ Chromosome of focus _____	<input type="checkbox"/> Cell Culture Only <input type="checkbox"/> Cell Culture/send out <input type="checkbox"/> Cryopreservation of cells * <input type="checkbox"/> Thaw/Expansion of Cells <input type="checkbox"/> Save Cells for other tests <input type="checkbox"/> Send Out Specimen:	Reference Lab: _____ _____ Address: _____ _____ _____ Tel: _____
Research or Institutional Fund number for billing		

CYTOGENETICS TESTS PERFORMED AT

Cytogenetics Tests Performed at the Center for Advanced Molecular Diagnostics
 Brigham and Women's Hospital - 75 Francis Street Boston MA 02115 ·(857) 307-1500
 · Clinical Director: Cynthia Morton, Ph.D. (857) 307-1521 ·FAX (857) 307-1522
 CLIA ID#: 22D0705149 Frederick Schoen, M.D. Director

* Requires approval. Call (857) - 307-1500 Reflex or confirmatory testing for Chromosome analysis and/or FISH , may include additional FISH probes, or further chromosome analysis and interpretation on the sample submitted.
 1. Required field for specimen processing 2. Diagnosis code based on specimen type & specific analyses performed