BRIGHAM AND WOMEN'S HOSPITAL
75 Francis Street, Boston, Massachusetts 02115

Lab Requisition

CAMD

Constitutional Cytogenetics

Name
MRN
DOB
M/F

Location/Institution	Reserved For CAMD Sticker
ICD Code(s) **REQUIRED** *(ICD-10-CM codes required as of 10/1/15.)*	

Collection Information

Date	Time	Drawn by: Phleb. ID	Drawn by: MD/RN ID

Ordering Clinician: Please print First, Last name	Clinical ID/NPI#	Contact Name & Phone Number

Clinician Signature: (Required)	Clinician's Fax Number for Patient Reports:	Clinician's Phone Number:

Send Duplicate Reports To: (Name/Address/Fax#/Phone)

SPECIMEN SUBMITTED:
☐ Amniotic Fluid ☐ Chorionic villus ☐ Peripheral Blood
☐ PUBS ☐ Cord Blood ☐ POC ☐ Other: _____
☐ Tissue: Indicate type _____ ☐ BWH Pathology Accession/ Block # _____

Clinical History:

Tests Requested		Indication for Testing	Pregnancy History
	SNP Microarray	*Please provide additional details under Clinical History:*	G _____
	Parental follow up to a SNP microarray (additional charges apply)	☐ Short stature ☐ Multiple congenital anomalies ☐ Developmental delay	P _____ SAB _____
	Standard chromosome analysis **R**	☐ Infertility ☐ Azoospermia/oligospermia ☐ Premature ovarian failure	TAB _____
	FISH (not performed routinely with SNP arrays) Probe(s)/Chromosome(s) of Focus:	☐ History of recurrent SAB ☐ Abnormal cffDNA result *List abnormal chromosome(s):*	Gestational age:
	AFP (testing performed at BWH Reproductive Endocrinology)		Does Patient wish to know fetal sex? ☐ Yes ☐ No
	ACHE (testing performed at FBR)	☐ Abnormal maternal screen ☐ Increased risk of trisomy ☐ Increased risk of NTD	
	Save unspun amniotic fluid for CMV/Toxoplasma testing		
	Save cells	☐ Abnormal ultrasound *List findings under clinical history*	Multiple Gestation ☐ Yes ☐ No
	Send out DIRECT specimen (indicate sample type and quantity):	☐ Advanced maternal age ☐ Family history chrom. abnormality ☐ Other:	If yes, please indicate number: _____
	Send out CULTURED specimen (indicate sample type and quantity):		
	Cryopreservation of cells – stored for 6 months only (Requires advance approval by Laboratory)	Reference Laboratory (name and telephone #):	

☐ **By submission of this sample and request for genetic testing, I hereby warrant that the appropriate prior written consent has been obtained from the patient or authorized representative.**

Provider signature: _____ **Date:** _____/_____/_____

R Reflex or confirmatory testing, if required, will be performed, reported and billed unless indicated here: ☐ No reflex tests

Brigham and Women's Hospital, Center for Advanced Molecular Diagnostics, Cytogenetics Laboratory
75 Francis Street Boston, MA 02115 Shapiro 5-5032
Tel: (857) 307-1500 FAX (857) 307-1522