BRIGHAM AND WOMEN'S HOSPITAL
*A Teaching Affiliate of Harvard Medical School*
*75 Francis Street, Boston, Massachusetts 02115*

**Lab Requisition**

# CAMD

Name
MRN
DOB
M/F

## CYTOGENETICS: PRENATAL REQUISITION

Location/Institution: MGH

Reserved For CAMD Sticker

ICD-9 Code(s): (Required)
758.00

**Collection Information**

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

Ordering Clinician: Please print First, Last Name

Clinical ID/NPI#

Contact Name & Phone Number

Clinician Signature (Required)

Fax Number for Patient Reports

Clinician's Phone Number

Send Duplicate Reports To: (Name/Address/Fax#/Phone#)
MGH Down Syndrome Program, downsyndrome@partners.org, FAX 617-726-1566

SPECIMEN SUBMITTED: ☐ Amniotic Fluid ☐ Chorionic Villi Sample ☐ Peripheral Blood ☐ PGD/Embryo
☐ POC ☐ PUBS ☐ Cord Blood ☐ Other: _____
Tissue: Type _____ ☐ BWH Pathology Accession/ Block # _____

Clinical/Gestational History: Newborn with suspected Down Syndrome

| | Tests Requested |
|---|---|
| ✓ | Chromosome Analysis R |
| | Alpha FetoProtein – to BWH Chemistry |
| | ACHE – to FBR |
| ✓ | FISH: (Fluorescence *In-Situ* Hybridization) Probe/Chromosome of Focus: 21 |
| | aCGH (Array based Comparative Genomic Hybridization) |
| | Save Unspun Amniotic Fluid |
| | Send Out Direct Specimen |
| | Cell Culture only |
| | Save cells for other tests: |
| | |
| | |
| | Send-out Cultured Specimen |
| | Cryopreservation of Cells – Requires approval (stored for 6 months) |
| | Thaw/Expansion of cells |

**Prenatal Indications:**

- ☐ Abnormal Maternal Screen
  - Increased Risk of NTD
  - Increased Risk of Trisomy
- ☐ Advanced Maternal Age
- ☐ Abnormal Ultrasound
  - Specify: _____
- ☐ Family Hx NTD
- ☐ Family Hx Chrom Abn.
- ☐ Multiple SAB's
- ☐ Maternal Anxiety
- ☐ Other: _____

**Pregnancy Data**

G _____ P _____

SAB _____ TAB _____

Gestational Age:

Does Patient wish to know the sex of the fetus?
☐ Yes ☐ No

☐ Multiple Gestations?

SEND OUT INFORMATION:

Reference Lab:

Address:

Telephone:

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**
**CLIA ID#: 22D0705149**