HealthLab
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HEALTHLAB

Chromosome Studies

Referring hospital: Central DuPage Hospital-HealthLab (**Bill our Account**)

Patient name: _____

Date of birth: _____ Social Security: _____

Patient sex (please circle): Male Female

Referring physician: _____

Address: _____

City/State/Zip: _____

Fax: _____

Amniotic Fluid Testing requires a patient information form.

□ Chromosomes- amniotic fluid	**AMC HRM**	□ *FISH* probe for: _____	**AFISH**
□ AFP (Alpha Fetoprotein)- amniotic fluid	**AMAFP**	□ Chromosomes- bone marrow/ leukemic blood	**BNCHRM**
□ ACHE (Acetycholinesterase)- amniotic fluid	**AMACHE**	□ Chromosomes, tissue with tissue culture-products of conception	**TSCHRMTSET**
□ Prenatal *FISH*, amniotic fluid	**AMFISH**		
□ Chromosomes, blood	**ACHRM**		
□ Fragile X DNA ONLY, blood	**FMR1**		
□ Chromosomes, partial-blood	**BLCHRM**		

Indication for test:

□ r/o trisomy 21 (Down syndrome)
□ r/o trisomy 18
□ r/o trisomy 13
□ r/o Turner syndrome
□ r/o XXY (Klinefelter syndrome)
□ r/o fragile x: indicate which test(s)
  □ Chromosome and DNA-Fragile X
  □ DNA-fragile X only-no chromosomes
□ Retardation
□ Multiple miscarriages
□ Infertility
□ Family history of:_____
□ Other indications: _____
□ FISH probe for:_____

Please complete all information and attach this form to the test requisition.
Send both with the specimen in the transport bag to the laboratory.