

Chromosome Studies

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

Patient name _____

Date of birth _____ Social Security _____

Patient sex (please check): Male Female

Referring physician _____

Address _____

City _____ State _____ ZIP _____

Fax _____

Amniotic Fluid Testing requires a patient information form.

<input type="checkbox"/> Chromosomes- amniotic fluid	AMC HRM	<input type="checkbox"/> FISH probe for _____	AFISH
<input type="checkbox"/> AFP (Alpha Fetoprotein)- amniotic fluid	AMAFP	<input type="checkbox"/> Chromosomes- bone marrow/ leukemic blood	BNCHRM
<input type="checkbox"/> ACHE (Acetylcholinesterase)- amniotic fluid	AMACHE	<input type="checkbox"/> Chromosomes, tissue with tissue culture-products of conception	TSCRMTS ET
<input type="checkbox"/> Prenatal FISH, amniotic fluid	AMFISH		
<input type="checkbox"/> Chromosomes, blood	ACHRM		
<input type="checkbox"/> Fragile X DNA ONLY, blood	FMR1		
<input type="checkbox"/> Chromosomes, partial-blood	BLCHRM		

Indication for test:

- | | |
|---|---|
| <input type="checkbox"/> r/o trisomy 21 (Down syndrome)
<input type="checkbox"/> r/o trisomy 18
<input type="checkbox"/> r/o trisomy 13
<input type="checkbox"/> r/o Turner syndrome
<input type="checkbox"/> r/o XXY (Klinefelter syndrome)
<input type="checkbox"/> r/o Fragile X: indicate which test(s)
<input type="checkbox"/> Chromosome and DNA-Fragile X
<input type="checkbox"/> DNA-Fragile X only-no chromosomes | <input type="checkbox"/> Retardation
<input type="checkbox"/> Multiple miscarriages
<input type="checkbox"/> Infertility
<input type="checkbox"/> Family history of _____
<input type="checkbox"/> Other indications _____
<input type="checkbox"/> 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.