



# IBR Specialty Clinical Laboratories

1050 Forest Hill Road, Staten Island, New York 10314-6399

(718) 494-5345 fax (718) 494-0694

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 Director, Institute for Basic Research  
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## CYTOGENETICS REFERRAL FORM

### Patient Information

Last Name	First	M.I.	D.O.B. (mm/dd/yyyy) / /	SEX [ ] M [ ] F	Diagnosis: ICD-9CM
Street Address	Apt. #	Telephone #		Facility Consecutive # / Patient ID #	
City	State	Zip			

### Person Responsible For Bill (Outpatients Only)

Last Name	First	Insurance Carrier Completed Insurance Form <b>or</b> Copy of Medicaid card required			
Street Address	Apt. #	Telephone #		ID #	
City	State	Zip			

### Physician Information

Last Name	First	MMIS # or Lic. #	State	Number - Facility	
Street Address	Apt. #	City		State	Zip
Fax ( )	Physician's Signature		Date: / /		
Telephone ( )					

**By law, test cannot be performed without physician and patient authorization – see page 2.**

Collection Date: / /	[ ] Initial Study [ ] Follow-up	<b>Specimens Accepted Monday – Friday</b> Submit specimens immediately in sterile tubes at room temp.
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<u>Please Check Test(s)</u>	<u>Specimen Information</u>	<u>Patient Information</u>
<input type="checkbox"/> 300 ROUTINE Blood <input type="checkbox"/> 301 ROUTINE Amniotic Fluid <input type="checkbox"/> 302 HIGH-RESOLUTION Blood* <input type="checkbox"/> 303 MOSAICISM Blood* <input type="checkbox"/> 304 MOSAICISM Skin* <input type="checkbox"/> 307 SKIN, TISSUE <input type="checkbox"/> 308 ALPHA-FETOPROTEIN <input type="checkbox"/> 315 FISH <input type="checkbox"/> OTHER Chromosome suspected: _____ Syndrome suspected: _____ *requires clinical summary	<input type="checkbox"/> Whole Blood: One Green-Top Tube (sodium heparin) or 5 ml blood in heparinized syringe. 1 ml minimum for infant.  <input type="checkbox"/> Skin: 2-3 mm <sup>3</sup> in Sterile Tissue Culture Medium  <input type="checkbox"/> Amniotic Fluid: 30 ml  <input type="checkbox"/> Other	Mental Retardation Medication <input type="checkbox"/> Yes [ ] No [ ] Yes [ ] No Reason for Referral: _____ _____ _____ Date of LMP: ____/____/____ Gestational Age by Ultrasound: _____ Wk _____ Days

### ... For Lab Use Only ...

Accession Number	Date / /	By:	Reviewed By:
Date Rec'd in Lab / /	# Cells Studied:	Karyotype Description:	
G #	Image / Karyotype:		
C #	FISH: # Cells Studied	[ ] 312 Banding	
P #		[ ] 313 Blood [ ] 314 Skin No Growth	



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**Purpose of Test: To determine if the client has a chromosomal abnormality.**

X	Type of Test	Brief Description
	Routine Analysis	Analysis of chromosomes for abnormalities such as structural abnormalities and aneuploidy (e.g., Down syndrome, Turner syndrome). This test may be supplemented by FISH and/or other banding techniques to clarify the results of our diagnosis.
	High Resolution	Analysis of discrete chromosomal abnormalities: microdeletions (e.g., Prader-Willi, Angelman, and DiGeorge syndromes) and other structural abnormalities. This test may be supplemented by FISH and/or other banding techniques to clarify the results of our diagnosis.
	Mosaicism	Analysis of chromosomes for the presence of more than one distinct cell line. This includes a routine analysis. This test may be supplemented by FISH and/or other banding techniques to clarify the results of our diagnosis.
	Alpha-Fetoprotein	Assay to detect the increased risk of open neural tube defects.
	Additional Banding Techniques	Techniques used to characterize chromosomal abnormalities. Examples: Q-banding, R-Banding, C-Banding, NOR staining, SCE staining.
	FISH (Fluorescence in situ hybridization)	Test to characterize and/or detect chromosomal abnormalities by staining with DNA probes specific for individual chromosomes or parts of chromosomes. A FISH analysis must always be accompanied by or follow standard G-banding analysis.

A positive test result is an indication that you may be predisposed to or have that condition and may wish to consider further testing, to consult your physician, or to pursue genetic counseling not only in the event of a positive result but even before consent for testing is given. Because this is an in vitro test, it is accurate within its technical limits. Please indicate to whom you wish results to be disclosed. It is our policy to send results only to the physician or facility that ordered the test, without further written consent.

No tests other than those authorized or needed to confirm a result shall be performed on the sample unless you give your permission below to use any extra sample for research (with Institutional Review Board approval). If you don't give authorization, then the sample will be discarded within 60 days after receipt unless further retention is specifically authorized below.

**I understand the above and give consent for diagnostic testing only.**

\_\_\_\_\_  
*Signature of Subject or Parent/Guardian*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Witness*

I understand that names and other identifiers will be removed from the sample to protect my privacy. I authorize the laboratory to keep such samples for an indefinite length of time.

**I understand the above and give consent for diagnostic testing and for use of the remaining sample for research.**

\_\_\_\_\_  
*Signature of Subject or Parent/Guardian*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Witness*