

VANCOUVER GENERAL HOSPITAL
CYTOGENETICS LABORATORY

855 West 12th Avenue
 Vancouver, BC, V5Z 1M9
 Tel: 604-875-4129
 Fax: 604-875-4333

DATE

NAME

DATE OF BIRTH SEX F M

PHN

REQUISITION

INPATIENT OUTPATIENT

Patient's Address:

VGH Cytogenetics Number

Referring Physician:
 Billing #/Phone:
 Address:

Medical Genetics Number

Genetic Counsellor/Phone:

Additional Reports To:

CLINICAL DIAGNOSIS (Analysis will not be performed unless relevant clinical information is provided)

Please specify:

- Recurrent pregnancy loss, Infertility *Partner of:*
- Oligo-azoospermia, Amenorrhea *Describe phenotype:*
- Developmental delay/ Congenital abnormalities
Describe phenotype:
- Family history of chromosome abnormality
Include name(s), relationship, karyotype(s):
Cytogenetics lab where analysis was performed:
- Other *Specify:*

Is patient pregnant? Yes No

Hematologic neoplasia (*specify*)

LMP:

Routine Priority
 Hematopathologist:

TEST REQUESTED Karyotype FISH (*Specify*)

Prader-Willi/Angelman and Fragile X syndromes: specific testing is done by molecular techniques. Please send a separate blood sample in EDTA (1x7ml) to the Molecular Genetics Laboratory, BC C&W

SPECIMEN Blood (in 5 ml Sodium Heparin tube, room temperature) Bone Marrow Other (*specify:*)

Collection Date: Collection Time:

CG LABORATORY USE ONLY

Date Received: High Resolution
 Date Incubated: C Banding
 Number of Cells: NOR Staining
 Analyzer: FISH
 Mosaicism

VGH ACCESSIONING

of BM Spec. Received
 15 mL media tube
 NaHep tube
 Slides
 Other.....