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

VGH Cytogenetics Number

Patient's Address:

Medical Genetics Number

Referring Physician:
Billing #/Phone:
Address:

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

LMP:

☐ Hematologic neoplasia *(specify)*

☐ 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: ....
Date Incubated: ....

Number of Cells: ....
Analyzer: ....

☐ High Resolution
☐ C Banding
☐ NOR Staining
☐ FISH
☐ Mosaicism

VGH ACCESSIONING

# of BM Spec. Received

.... 15 mL media tube
.... NaHep tube
.... Slides
.... Other..............