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|--|------------------------------------|-----------------------|--------|
| Seattle Children's MRN: | Seattle Children's Account Number: | Processed By: | Date: |
| FAILURE TO COMPLETE MAY DELAY RESULTS | | | |
| Patient's Last Name | | First | Middle |
| | | Birth date (required) | |
| | | Sex | |
| Outside Patient Number | Outside Specimen Number | Send Report To: | |
| Referring Provider | | Address: | |
| Provider Phone Number | DIAGNOSIS / ICD-9: | Phone/Fax #: | |
| ***REQUIRED INFORMATION***: | | | |
| Healthcare professional to call for information/abnormal results: NAME (please print): _____ PHONE#: _____ | | | |

SPECIMEN INFORMATION: Date collected: ___ / ___ / ___
Time collected: _____

Whole Blood: Na Heparin Other (tissue / fibroblast): _____
 EDTA ACD _____

| ARRAY CGH TESTING (Requires EDTA Purple Top AND NaHEP Green Top) |
|--|
| CH-ARRAY <input type="checkbox"/> Array CGH PAR-ARRAY <input type="checkbox"/> Parental follow-up |
| CYTOGENETIC TESTING |
| CH-KARY <input type="checkbox"/> Peripheral blood karyotype CH-KARY <input type="checkbox"/> Peripheral blood karyotype + R/O mosaicism for _____ CH-FISH <input type="checkbox"/> Fluorescence <i>in situ</i> hybridization (FISH) <input type="checkbox"/> Velocardiofacial (VCF)/DiGeorge Syndrome 22q11.2 deletion/duplication syndrome <input type="checkbox"/> Williams Syndrome <input type="checkbox"/> Other: _____ CH-FAMS <input type="checkbox"/> Family Study (limited work-up; provide pedigree) CH-KARY <input type="checkbox"/> Workup for Turner Syndrome CH-KARY <input type="checkbox"/> Workup for ambiguous genitalia (includes 10 metaphase cells by SRY FISH + 20 metaphase cells by G-bands) |
| SKIN FIBROBLAST TESTING |
| CH-SKIN <input type="checkbox"/> Solid Tissue - Fibroblast culture ONLY CH-SKIN <input type="checkbox"/> Solid Tissue - Fibroblast culture + Karyotype CH-SKIN <input type="checkbox"/> Other Tissue Karyotype: Source: _____ |

| CLINICAL FINDINGS & FAMILY HISTORY |
|------------------------------------|
| (OPEN SPACE FOR PEDIGREE) |

