

Institute of Kidney Disease & Research Centre

Baliyalimdi, Asarwa, Ahmedabad – 380 016, Gujarat, India
DEPARTMENT OF OBSTETRICS AND GYNECOLOGY

CYTOGENETICS REQUISITION FORM

All Information Must Be Complete Before Sample Can Be Processed

PATIENT INFORMATION

Patient Name: _____
Last First Middle

MR#: _____ Date of Birth: ____/____/____ Gender: Male Female

Mother's Name: _____ Date of Birth: ____/____/____ Age: _____
Last First Middle

Father's Name: _____ Date of Birth: ____/____/____ Age: _____
Last First Middle

Address: _____, City: _____, State: _____, PIN: _____

Phone: (____) _____ Fax: (____) _____ Email: _____

SAMPLE / SPECIMEN INFORMATION

- Amniotic Fluid Product of Conception
 CVS Peripheral Blood
 Others _____ (specify)

Specimen Date: ____/____/____ Time: ____: ____

Pregnancy Data for Prenatal Sample: (Multiple gestation - separate requisitions)

Ultrasound Date: ____/____/____

GA on US Date: ____wks ____days

LMP: ____ GA by LMP: ____wks ____days

G ____ P ____ SAB ____ TAB ____

LABORATORY TESTS ORDERED

- Chromosome Analysis'
 If chromosomes are normal. reflex to microarray - Parental samples recommended for Prenatal Microarray
- Prenatal Aneuploidy FISH Panel (FISH for 13, 18, 21, X and y)
- Microdeletion & Cryptic Translocation FISH Panel Velocardiofacial (DiGeorge) Syndrome (deletion 22q11.2) FISH
- Prenatal Microarray 315k
 Postnatal Microarray 750k
 DNA storage

Parental Sample Information for Prenatal Microarray:

- Maternal sample included for MCC

REFERRING PHYSICIAN

Hospital Name: _____

Physician Name: _____

Address: _____

Phone: (____) _____ Fax: (____) _____

Email: _____

Genetic Counsellor / Lab Contact Name: _____

Phone: (____) _____ Fax: (____) _____

Email: _____

Date: ____/____/____

Referring Physician Signature (REQUIRED)

INDICATIONS FOR DIAGNOSIS

- Abnormal maternal serum / first trimester screen. Increased risk of:
 NTD Down syndrome Trisomy 18
 Others (specify): _____
- Abnormal fetal ultrasound: _____
- Recurrent Miscarriage
- Family History: _____
- Advanced Maternal Age
- Infertility
- Consanguinity (please specify relationship): _____
- Abnormal Sexual Development
- Other

CONSENT FORM: Consent to carry out Chromosome Study on Chorionic Villi / Amniotic Fluid / Abortus Material / Bone Marrow / Blood

I/We give my/our consent to carry out Genetic study at above mentioned facility, as a diagnostic test.

The test may be unsuccessful on rare occasions. An additional sample may be needed if the test is unsuccessful, or if the sample is damaged in shipment or in accurately submitted.

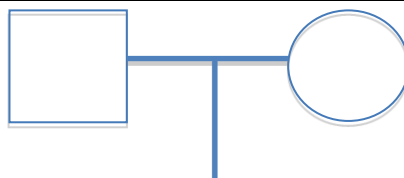
It is further agreed that the nature of this agreement is such that it must remain confidential and we agree that the sole copy of the agreement may be retained in by the above doctors file shall not be disclosed expect under unavoidable circumstances.

I give permission to use clinical information /Video / Photographic material relating to publication in any scientific journal /Book.

Date: _____ Place: _____ Name (in block): _____ Signature: _____

Witnesses: Name (in block): _____ Signature: _____ Name (in block): _____ Signature: _____

PEDIGREE



REPORT

Blood Counts:			Remarks / Notes:
Bone Marrow Counts:			
Folate:	B12:	HCY:	
TORCH:	aPL:	VDRL:	
ANA:			
USG Findings:	NT:	Nuchal Fold:	
Triple Marker Results:	AFP:		
Quadruple Marker Results:	HCG:		
	UE ₃ :		
	Inhibin:		

Risk for Trisomy 21/ 18/ 13
Ratio:

INSTRUCTIONS FOR SAMPLING TISSUE FOR CYTOGENETIC ANALYSIS

Each specimen must be clearly labelled with patient name and birth date. Requisition must supply name, birth date, gender, physician, originating lab or clinic, and clinical indication. Overnight shipping is acceptable where necessary.

Peripheral Blood

5 – 10 cc blood in green top vacutainer (Sodium Heparin) for adults and 1-2 cc for infants. Do not use lithium heparin or ammonium heparin. Mix well by inverting. Sample to be maintained at R.T. Samples should arrive within 48 hours (preferably 24 hours) of sampling. [For DNA extraction – 5ml venous blood in EDTA tube]
study time: 10 – 20 days.

Amniotic Fluid

15 – 20cc sterile amniotic fluid in two sterile screw-capped tubes (centrifuge tubes). First 2ml drawn should be discarded to reduce chance of maternal cell contamination. If prenatal interphase FISH is also desired, a minimum of 20ccs of amniotic fluid is required. Label with (a) Patients name (b) Gestational Age (c) Doctor's Name (d) Date and time drawn. Specimen to be kept at R. T.
Study time: 14– 24 days.

Chorionic Villus Studies

This is studied at 10 – 13 weeks of pregnancy for various chromosomal & single gene disorders. Collect 15 to 20 mg of good quality chorionic tissue in the provided media in aseptic condition & send it to laboratory.
Study time: One week to 3 weeks depending on the type of investigation.

Product of conception-Fetal Tissue/Placenta

Selected tissue specimens should be obtained from abortus material. Preferred tissues are maternal cartilage, skin from the upper arm or thigh, fetal membranes, cord or placenta near cord attachment. In the case of an IUFD, send both fetal tissue (preferably toe tissue) and a specimen of placenta. Preferably collected in a tissue culture media (RPMI); if not available use Sterile Saline. Fill tube completely. Cap tightly and cover with parafilm. Refrigerate at 4-8°C until shipment (Do not freeze)
Study time: 3 – 4 weeks.

All samples are to be sent immediately to Genetics Laboratory, room no.6018, 6th floor, IKDRC, Baliyalimdi, Asarwa, Ahmedabad. If sample delivery is delayed, please refrigerate but DO NOT FREEZE. Contact Genetics Laboratory if there are any questions about sample collection. The Genetics lab should be notified before any tissue is sent for chromosome studies.

Requisitions must be sent with all samples. Ph no. 07922687513, 07922687500