

UCSD MEDICAL GENETICS

Phone: 858-534-4307 Fax: 858-534-0269



CYTOGENETICS LABORATORY
Marie Dell'Aquila, Ph.D., Director

MOLECULAR GENETICS LABORATORY
Linda Wasserman, M.D., Ph.D, Director

DO NOT WRITE HERE

GENETICS LAB NO. _____

Date/Time Received: _____

Tube: _____

Volume: _____

_____ lav/green top DNA Lab

PATIENT INFORMATION

PATIENT ID # _____

PATIENT NAME (Last, First, MI)

SEX

BIRTHDATE

TIME DRAWN

DATE DRAWN

PATIENT ADDRESS (Street, City, State, Zip)

RACE

PHONE NUMBER

BILLING INFORMATION

ATTACH COPY OF **INSURANCE CARD** (FRONT AND BACK)

AUTH# _____

OR INSTITUTION BILLING: KAISER NAVY SRS TRI-CITY VA SHARP CHHC OTHER

SCRIPPS CLINIC GREEN MEMORIAL MERCY RB CV ENC

PHYSICIAN INFORMATION

REFERRING PHYSICIAN

PHYSICIAN PHONE NO.

PHYSICIAN FAX NO.

ADDRESS (Street, City, State, Zip)

ADDITIONAL COPIES TO:

SEE REVERSE FOR SPECIMEN COLLECTION GUIDELINES

SPECIMEN TYPE	TEST(S) REQUESTED	
<p>_____ Amniotic Fluid (includes AFP)</p> <p>Gestational Age by Sono _____</p> <p>_____ Chorionic Villi</p> <p>_____ Blood (Standard)</p> <p>_____ Blood (Leukemia)</p> <p>_____ Bone Marrow</p> <p>_____ Buccal Swab (DNA only)</p> <p>_____ Products of Conception</p> <p>_____ Tumor</p> <p>_____ Lymph Node</p> <p>_____ Core BX</p> <p>_____ Other Tissue Type:</p> <p>Specify: _____</p> <p>DIAGNOSIS:</p> <p>ICD-9 Code(s):</p>	<p>CYTOGENETIC TESTING (Sodium-heparin green-top) 858-534-1352</p> <p>_____ Chromosomes/karyotype</p> <p>FISH (MICRODELETION)</p> <p>_____ Angelman syndrome</p> <p>_____ Cri du Chat syndrome</p> <p>_____ DiGeorge/VCFS syndrome</p> <p>_____ Miller-Dieker syndrome</p> <p>_____ Prader-Willi syndrome</p> <p>_____ Smith-Magenis syndrome</p> <p>_____ STS/Kallman syndrome</p> <p>_____ Williams syndrome (elastin)</p> <p>_____ Other: _____</p> <p>FISH (PRENATAL)</p> <p>_____ Fetal aneuploidy screen</p> <p>FISH (ONCOLOGY)</p> <p>_____ BCR/ABL fusion</p> <p>_____ CLL panel</p> <p>_____ RARA flanking probes</p> <p>_____ CCND1/IGH</p> <p>_____ Other: _____</p>	<p>MOLECULAR TESTING (EDTA Lavender top or ACD-yellow top) 858-534-1353</p> <p>GENETIC TESTING</p> <p>_____ Cystic Fibrosis</p> <p>_____ CFTR Intron 8 Poly (T) Variant (CBAVD)</p> <p>_____ Fragile X Syndrome</p> <p>_____ FMR 1 Related Disorders (FXTAS, POF)</p> <p>_____ Huntington Disease</p> <p>_____ Angelman Syndrome (Methylation Analysis)</p> <p>_____ Prader Willi Syndrome (Methylation Analysis)</p> <p>_____ RhD Typing (Fetal)</p> <p>ASHKENAZI JEWISH GENETIC SCREENING</p> <p>_____ Panel 1: CF, TSD, CD, FD, FAC</p> <p>_____ Panel 2: BS, GSD, MLIV, NPJ</p> <p>_____ Gaucher Disease</p> <p>_____ Tay-Sachs Enzyme Analysis (Hex-A)</p> <p>THROMBOPHILIA PANEL</p> <p>_____ Factor V Leiden (R506Q) Mutation</p> <p>_____ Prothrombin G20210A Mutation (Factor II)</p> <p>_____ MTHFR (C677T) Variant</p> <p>ONCOLOGY TESTING</p> <p>_____ BCR/ABL by RT-PCR (Qualitative)</p> <p>_____ JAK2 (V617F) Mutation</p> <p>PARENTAGE TESTING: PLEASE CALL 858-822-0100</p>

Please label specimen with patient name and date/time collected.

CHROMOSOMES/FISH 858-534-1352

SAMPLE TYPE	SPECIMEN AND HANDLING	ADDITIONAL INFORMATION
Amniotic fluid	<ul style="list-style-type: none"> 20 ml of fluid-optimal Any volume will be accepted. Keep at room temperature. 	If tests other than karyotype analysis and alpha-fetoprotein assay are desired, please provide information.
Blood <ul style="list-style-type: none"> Routine Leukemic 	<ul style="list-style-type: none"> 3 ml of whole blood in sodium heparin (green top) vacutainer tube; lithium heparin <u>not</u> recommended. Refrigerate if stored overnight. 	Provide phenotype or clinical findings.
Bone marrow	<ul style="list-style-type: none"> 2-3 ml of whole marrow in sodium heparin. Refrigerate if stored overnight 	Provide diagnosis under consideration.
Tissue <ul style="list-style-type: none"> Products of conception Fetal Skin biopsy <ul style="list-style-type: none"> Solid tumors 	<ul style="list-style-type: none"> Place in sterile container, immerse in a balanced salt solution (e.g. normal saline). Refrigerate if stored overnight. Process as above but do not store or refrigerate. 	Preferred fetal tissues are: Fascia lata Cartilage Placenta <u>NO FIXATIVE</u> Large amounts are not required: A 1-2cm piece of each tissue type is sufficient. Tumor specimen should be received in lab same day or call.

DNA 858-534-1353

SAMPLE TYPE	SPECIMEN AND HANDLING*	ADDITIONAL INFORMATION
Amniotic fluid or Chorionic villi	<ul style="list-style-type: none"> Call for requirements. 	For further information or questions, call 858-534-3093.
Buccal swab	<ul style="list-style-type: none"> Call for requirements. 	
Blood	<ul style="list-style-type: none"> 3 ml of whole blood EDTA (purple top) vacutainer tube. 	
Tissue	<ul style="list-style-type: none"> 0.5 cm³ of tissue in transport media or sterile saline. 	

*These guidelines are offered for optimal conditions. It is recognized that there will be exceptions (i.e. volume, time of week or time of day, etc.)