Brigham and Women's Hospital
Founding Member, Mass General Brigham

Lab Requisition
CAMD

Constitutional Cytogenetics

Name

MRN

DOB

Sex at birth

Location/Institution

Reserved For CAMD Sticker

ICD Code(s) **REQUIRED**

(ICD-10-CM codes required as of 10/1/15.)

Collection Information

Date	Time	Drawn by:	
		Phleb. ID	MD/RN ID

Ordering Clinician: Please print First, Last name

Clinical ID/NPI#

Contact Name & Phone Number

Ordering Clinician Address:

Clinician Signature: (Required)

Clinician's Fax Number for Patient Reports:

Clinician's Phone Number:

Send Duplicate Reports To: (Name/Address/Fax#/Phone)

SPECIMEN SUBMITTED: ☐ Amniotic Fluid ☐ Chorionic villus ☐ Peripheral Blood

☐ PUBS ☐ Cord Blood ☐ POC ☐ Other: ____________________

☐ Tissue: Indicate type ____________ ☐ BWH Pathology Accession/ Block # ____________________

Special Handling Instructions (optional)

Clinical History and Indication:

	Tests Requested	Pregnancy Data
	SNP Microarray R	Gestational age:
	Chromosome analysis R	
	FISH R (please indicate probe(s)):	
	Send out DIRECT specimen (indicate quantity and provide paperwork):	Multiple Gestation ☐ Yes ☐ No
	Send out CULTURED specimen (indicate quantity and provide paperwork):	If yes, please indicate number:
	DNA isolate and hold This request to be fulfilled only with a concurrent SNP microarray. DNA will be saved for 6 months.	
	Viral testing (please indicate viral test(s)):	

☐ **By submission of this sample and request for genetic testing, I hereby warrant that the appropriate prior written consent has been obtained from the patient or authorized representative.**

Provider signature: ____________________ **Date:** ____/____/____

R Reflex or confirmatory testing, if required, will be performed, reported and billed unless indicated here: ☐ No reflex tests

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