# Cytogenetics Requisition and Clinical History Form

**MLabs**  
Department of Pathology  
SP 2F367 UH, SPC 5054  
1500 E. Medical Center Drive  
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734-936-2598  
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### Specimen Type

- **Peripheral Blood**
- **Bone Marrow Aspirate**
- **Bone Marrow Biopsy/Bone Core**
- **Lymph Node**
- **Other:**

- **Skin biopsy, Source:** _____________________________________

- **Fetal/Stillbirth**
- **LMP** ____________________

- **Products of Conception (POC)**
- **Gest. Age:** _________________

- **Placenta**
- **GA by LMP or U/S?** _________________

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### The following must be completed before testing is performed

**CONSTITUTIONAL/GENETICS:**

- **Chromosome Analysis (Routine Karyotype)**
- **FISH for Microdeletion Syndromes (select below)**
  - DiGeorge/VCF (22q11.2)
  - Prader-Willi (15q11.2)
  - Angelman (15q11.2)
  - Smith-Magenis (17p11.2)
  - Miller-Dieker (17p13.3)
  - Williams (7q11.23)
  - Microduplication of 15q11-q13
- **Other:**

**DISEASE STATUS:**

- **Initial specimen (pretreatment)**
- **Known to be complete remission**
- **Possible remission**
- **Known to have residual disease**
- **Known to have disease in relapse**
- **CML:**
  - Chronic phase
  - Acute phase
  - Remission

Proven BCR/ABL positive by:

- **RT-PCR**
- **FISH**
- **Chromosomes**

**Previous karyotype results:**

**If suspected secondary malignancy:**

- **Primary malignancy:**

**Treatment (RT, CT, etc):** ______________ Date: ______________

**Previous Cytogenetics results:**

### TREATMENT HISTORY:

**Patient's current medications:**

**Types of therapy received to date for current disease:**

- **None**
- **Radiotherapy**
- **Chemotherapy**

- **Gleevec**
- **Other (indicate drug):**

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**Please note:** Additional testing and/or charges may be associated with Cytogenetic testing. Please refer to the MLabs Handbook.

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**FOR ALL INSURANCE & MEDICARE PATIENTS**

I understand that Medicare or my private insurance carrier may not pay for tests that it determines are not reasonable or necessary for my diagnosis. If Medicare or my private insurance carrier denies payment, I agree to be personally responsible for the entire payment. I also authorize any holder of medical, demographic or billing information about me to release it to my insurance carrier for purposes of determining payment of medical insurance benefits.

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**Patient Signature:**

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**ICD-9 Codes are required for billing. A partial list is provided on the back of this requisition.**

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