# Cytogenetics Congenital Testing Request Instructions

Allina Health LABORATORY

**Complete the requisition in its entirety, including:**

1. Billing Preference
2. Date & Time of Specimen Collection
3. Patient name, date of birth and address **(Must include two patient identifiers)**
4. Insurance information if testing is to be billed to insurance
5. Clinical Indication for Testing
6. Ordering physician Signature and call-back information (phone/pager/fax number)
7. Referring physician and/or Genetic Counselor names and call-back numbers
8. Indicate if STAT service is required. Enter the phone number where the verbal preliminary report should be called (if different from the ordering physician). Call the Cytogenetics Lab at (612) 863-4541 prior to sending specimen.

***Specimen Type must be marked for proper processing. Mark each test clearly and answer all information requested within those section(s). Specimen requirements are provided on the back of the requisition. Call the Cytogenetics lab with any questions.***

## Section 1 – Postnatal Congenital Studies

9. **Postnatal Specimen Types:** The specimen type must be selected for proper processing.
10. **Postnatal Cytogenetic Tests: Chromosome Studies** - Select Standard Blood, High Resolution Blood, or Skin Biopsy chromosome test. Select "Tissue Culture Only" if the specimen is sent to culture and hold for future test orders. For newborn baby blood specimens, select STAT if a 48-72 hr. verbal preliminary result is needed and **call the Cytogenetics Lab prior to sending STAT specimen.**
11. **Chromosomal Microarray (CMA) Tests:** Select Chromosomal Microarray (CMA) test or the Combination test (combines a Limited Chromosome Study with a Microarray Analysis). Obtain consent for genetic testing and ensure genetic counseling is available to the family.
12. **FISH Tests:** Check box for specific test(s) requested. For aneuploidy FISH studies, select one panel: Aneuploidy Perinatal X/Y/18/13/21 Panel, Aneuploidy X/Y/18 Only Panel, or Aneuploidy 13/21 Only Panel. For unlisted FISH tests, consult with a Cytogenetics Director, select "Other", and list probes(s) requested.
13. **Postnatal Send out Tests:** List the specific send out test(s) needed and include accompanying paperwork with specimen requirements.
14. **Parental Studies:** For follow up parental or family studies, call the Cytogenetics Lab to discuss testing with a Director. Provide the name of the proband and initial proband case number, as well as the biological family members' names.

## Section 2 - Prenatal Congenital Studies

15. **Prenatal Specimen Types:** The specimen type must be selected for proper processing. For Products of Conception / Autopsy specimens, indicate tissue source.
16. **Prenatal Information:** Enter gestational age by Ultrasound. Enter: Gravida (G), Parity (P), Spontaneous Abortion (SAB) and Therapeutic Abortion (TAB) information.
17. **Prenatal Cytogenetic Tests:** Select Chromosome study, Chromosomal Microarray (CMA) test, or the Combination test (combines a Limited Chromosome Study with a Microarray Analysis).
18. **FISH Tests:** For aneuploidy FISH studies, select Aneuploidy Perinatal X/Y/18/13/21 Panel. Aneuploidy X/Y/18 Only or Aneuploidy 13/21 Only panels should be considered only after discussion with a Cytogenetics Director. The Expanded Aneuploidy Panel can be performed on POC specimens if a chromosome study is not possible. For additional FISH tests, consult with a Cytogenetics Director, select "Other", and list probes(s) requested.
19. **Prenatal Send out Tests:** Select a send out test; AFP, ACHE or "Other". If "Other" is selected, list testing requested. Select whether send out test should be performed on the direct specimen "DIRECT" or on cultured cells "CULTURES". Attach send out paperwork and any accompanying documentation (consent, family history, etc.). Select testing priority.
20. **Prenatal Holds:** Select if cultured cells should be held for additional test orders.

*LAB05*

**ALLINA HEALTH LABORATORY**
**CYTOGENETICS - CONGENITAL**
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www.allinahealth.org/laboratory

**BILL TO: MUST CHECK ONE ☐ CLIENT ☐ PATIENT/INSURANCE** 1

**DATE & TIME COLLECTED** 2 | DRAWN BY (AHL Staff use Tech # Only)

SOCIAL SECURITY # - - | ☐ MALE ☐ FEMALE | BIRTH DATE / /

**PATIENT NAME (LAST) (FIRST) (M.I.)** | CHART #

PATIENT ADDRESS (STREET) 3 CITY

STATE ZIP | PATIENT PHONE ( )

**INSURANCE**

☐ **MEDICARE PRIMARY** ☐ **MEDICARE SECONDARY**

MEDICARE

MEDICAL ASSISTANCE NUMBER 4 STATE

**FOR STAT SAMPLES:**

☐ **STAT Call to** (_____)_____ 8

INSURANCE CO. NAME | RELATIONSHIP OF PATIENT TO INSURED ☐ SELF ☐ SPOUSE ☐ DEPENDENT ☐ OTHER

**Clinical Indication for Testing:**

5

POLICY HOLDER'S NAME | POLICY HOLDER DATE OF BIRTH (IF NOT PATIENT) / /

SUBSCRIBER ID # | GROUP #

**Dx1** | **Dx2** | **Dx3** | **Dx4**

**Ordering Physician Signature** 6 | **Referring Physician** 7 | **Phone #**

**Clinician Phone #** | **Clinician Fax #** | **Genetic Counselor** | **Phone #**

## POSTNATAL CONGENITAL STUDIES

**POSTNATAL SPECIMEN TYPE (see back page for specimen requirements)** 9
- ☐ PERIPHERAL BLOOD (LAB4280F)
- ☐ CORD BLOOD (LAB4280F)
- ☐ SKIN BIOPSY (LAB4280D)

**POSTNATAL CYTOGENETIC TESTS** 10 — ☐ Check if STAT

| | | |
|---|---|---|
| ☐ STANDARD BLOOD CHROMOSOMES | | CSBLD |
| ☐ HIGH RESOLUTION BLOOD CHROMOSOMES | | CSHR |
| ☐ SKIN BIOPSY CHROMOSOMES | | CSPSK |
| ☐ TISSUE CULTURE ONLY | | POCFC |

**CHROMOSOMAL MICROARRAY (CMA) TESTS** 11
**(If CMA is requested on blood specimen–collect in both NaHep and EDTA tubes)**
- ☐ CHROMOSOMAL MICROARRAY – CMA — CTGE, CMAS
- ☐ COMBINATION TEST – Limited Chromosome Study P — MLBCS

**FISH TESTS** — ☐ Check if STAT

| | | |
|---|---|---|
| ☐ Aneuploidy Perinatal X/Y/13/18/21 Panel | | PERP |
| ☐ Aneuploidy X/Y/18 ONLY Panel | | XYO |
| ☐ Aneuploidy 13/21 ONLY Panel | | 13O |
| ☐ Angelman syndrome (AS) | 15q11.2 | ANG |
| ☐ Cri du Chat syndrome | 5p15.2 | CDC |
| ☐ DiGeorge/VCFS/CATCH22 (DGS) | 22q11.2 | DIG1 |
| ☐ DiGeorge II syndrome (DGS II) | 10p14 | DIG2 |
| ☐ Kallmann syndrome | Xp22.3 | KAL |
| ☐ Miller-Dieker syndrome (MDS) | 17p13.3 | MILD |
| ☐ Prader-Willi syndrome (PWS) | 15q11.2 | PRW |
| ☐ Smith-Magenis syndrome (SMS) | 17p11.2 | SMMG |
| ☐ Sotos syndrome | 5q35 | SOT |
| ☐ SRY | Yp11.3 | SRY |
| ☐ Steroid Sulfatase (STS) deficiency (X-linked ichthyosis) | Xp22.3 | STSX |
| ☐ Williams Beuren syndrome (WBS) | 7q11.23 | ELN |
| ☐ Wolf-Hirschhorn syndrome (WHS) | 4p16.3 | WHIR |
| ☐ XIST | Xq13.2 | XIST |

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☐ Other_____
Misc. Metaphase or Interphase FISH Study — METG or INTG

**POSTNATAL SENDOUT TESTS**
☐ SENDOUT TEST _____ — MSO 13
**(Attach Test Requirements and Other Documentation For Send Out)**

**PARENTAL STUDIES**
☐ FOLLOW-UP PARENTAL / FAMILY STUDIES **(Please call the lab to discuss)**
Proband Name:_____ Proband Case #: _____
Biological Mother:_____
Biological Father:_____ 14
Other Family Members:_____

## PRENATAL CONGENITAL STUDIES

**PRENATAL SPECIMEN TYPE (see back page for specimen requirements)** 15
- ☐ AMNIOTIC FLUID (LAB4280A)
- ☐ CHORIONIC VILLI (LAB4280B)
- ☐ FETAL BLOOD / PUBS (LAB4280F)
- ☐ PRODUCTS OF CONCEPTION (POC) / AUTOPSY (LAB4280C)
  ☐ Placenta ☐ Skin ☐ Tissue _____

**PRENATAL INFORMATION (Required)** 16
Ultrasound gestation = _____
G_____ P_____ SAB_____ TAB_____

**PRENATAL CYTOGENETIC TESTS** 17

| | |
|---|---|
| ☐ CHROMOSOME STUDIES | CSAF, CSCV, CSBLD, CSPSK |
| ☐ CHROMOSOMAL MICROARRAY – CMA | CTGE, CMAS |

**(Requires Maternal and Paternal blood specimens collected in EDTA tubes)**
- ☐ Biological Mother — MSO
- ☐ Biological Father (name) _____ — MSO

| | |
|---|---|
| ☐ COMBINATION TEST – Limited Chromosome Study Plus CMA | MLBCS |
| ☐ TISSUE CULTURE ONLY | AMCVC, POCFC |

**FISH TESTS** 18

| | |
|---|---|
| ☐ Aneuploidy Perinatal X/Y/13/18/21 Panel | PERP |
| ☐ Aneuploidy X/Y/18 ONLY Panel | XYO |
| ☐ Aneuploidy 13/21 ONLY Panel | 13O |
| ☐ Expanded Aneuploidy X/Y/13/16/18/21/22 Panel | ANEU+ |

**(Paraffin FISH study for POC specimens ONLY)**
☐ Other_____
Misc. Metaphase or Interphase FISH Study — METG or INTG

**PRENATAL SENDOUT TESTS** 19

| | |
|---|---|
| ☐ AFP | BAA |
| ☐ ACHE | ACB |
| ☐ OTHER SENDOUT _____ | MSO |

☐ DIRECT ☐ CULTURES
**(Attach Test Requirements and Other Documentation For Send Out)**
**SELECT TEST PRIORITY**
☐ CYTOGENETICS
☐ SENDOUT

**PRENATAL HOLD**
☐ Hold cultured cells:
_____ 20
_____
_____

Affix RQ Label Here

CYTOGEN-CONG (11/14)