Children's & Women's Health Centre of BC
Facility code: L1050

(Please use block letters)

DATE HOSPITAL UNIT#

SURNAME GIVEN NAMES

BIRTHDATE (d/m/y) SEX

PHN MEDICAL GENETICS#

Mother's name / DOB

Cytogenetics Requisition Products of Conception

☐ INPATIENT ☐ OUTPATIENT

HOSPITAL: _____

Referring Physician: **Billing#:**
Signature :_____
Address / Phone:

Cytogenetics use only

Addidional report to:

Gestational Age: _____ Gravida _____ Para _____ SA _____ TA _____

Clinical Information (analysis cannot be performed unless appropriate clinical history is provided)

☐ Recurrent spontaneous abortion
☐ Maternal age ≥ 35 years
☐ IUFD
☐ Embryo/foetal abnormality (Specify)
☐ Abnormal placenta (Specify)
☐ Previous liveborn/stillborn with chromosomal abnormality (Specify)
☐ Prenataly diagnosed chromosomal abnormality (Specify)
☐ FISH only (Specify)
☐ IVF / Infertility
☐ Parental chromosomal rearrangement (Specify)
☐ IUGR
☐ Other (Specify)

DO NOT CANCEL. Please direct any questions to the consulting pathologist.

Family History / Previous Karyotypes:

TEST REQUESTED: ☐ **Karyotype** ☐ **FISH** (Specify) ☐ **Other** (Specify)

SPECIMEN: ☐ Foetal tissue (Specify) ☐ Placenta ☐ Amnion/Chorion ☐ Other (Specify)

Date Taken: _____ **Hour:** _____ **Referring facility code:**_____ **Collected by:**

CYTOGENETICS LAB USE: Date arrived: _____ Date incubated: _____
Previous results:

Cytogenetics Laboratory, Department of Pathology and Laboratory Medicine, 4500 Oak Street, Vancouver BC V6H 3N1
Tel: 604 875 2304 Fax: 604 875 3601