# Genetic Test Request Form

**Department of Medical Genetics**
**Genetics Laboratories**
440 Burroughs Street
Detroit, MI 48202
Phone: 313-870-1700
Fax: 313-870-1701

Cytogenetics: Suite 446 Lab Hours: 8 am - 5 pm M-F, 8 am-12 pm Sat

DNA Diagnostics: Suite 447 Lab Hours: 8 am - 5 pm M-F

Required Patient Information

MRN :

NAME:

DOB: Sex:

Date Collected: ICD9 Code:

**Indication for Testing** (check all that apply)**:**

- ☐ Birth defects (please describe)
- ☐ Developmental delay
- ☐ Dysmorphic features (please describe)
- ☐ Hypotonia
- ☐ Infertility
- ☐ R/O Turner syndrome
- ☐ Primary amenorrhea
- ☐ History of pregnancy loss:

Gr_____ Para_____ Ab_____

- ☐ Asymptomatic
- ☐ Carrier testing
- ☐ Family history of (name disorder): _____
- ☐ Diagnostic testing
- ☐ Symptomatic
- ☐ Other : _____

**Ethnic Origin** (required for DNA testing)**:**

- ☐ Caucasian
- ☐ African-American
- ☐ Ashkenazi Jewish
- ☐ Hispanic
- ☐ Asian
- ☐ Arab-American
- ☐ Other: _____

Pedigree or clinical history:

Partner Name if appropriate: _____

## *Cytogenetic Analysis*

**Specimen Type:** *transport specimens at room temperature*

- ☐ Peripheral blood (10 ml in sodium heparin; 3 ml for infants; plus 1 EDTA tube if ordering Microarray)
- ☐ Skin biopsy (send in sterile media, Ringer's lactate or saline)
- ☐ Product of conception; tissue source: _____ (send in sterile media, Ringe's lactate or saline)
- ☐ **RUSH ANALYSIS:** reason: _____

**Test requested:**

- ☐ **Microarray (Array-CGH)**
  - ☐ Reflex to Chromosome analysis if normal
- ☐ **Chromosome analysis**
- ☐ **High resolution chromosome analysis**

**Fluorescent in situ hybridization (FISH)*:**

- ☐ Telomere panel
- ☐ DiGeorge/VCFS (22q11.2)
- ☐ FISH for molar pregnancy
- ☐ FISH for POC
- ☐ Ichthyosis, X-Linked (Xp22.3)
- ☐ Other (specify): _____

***FISH for specific deletion syndromes is available. Check 'Other' and specify or call lab (313-870-1700) to arrange.**

## *Molecular DNA Analysis*

**Specimen Type:** 10 ml peripheral blood in EDTA (2-3 tubes) is sufficient to perform **multiple** DNA tests
*Transport specimens at room temperature*

**Test Requested:**

- ☐ Angelman syndrome
- ☐ Biotinidase deficiency
- ☐ Cystic fibrosis
  - ☐ Intron 8 PolyT allele
- ☐ Familial Mediterranean fever
- ☐ Fragile X syndrome
- ☐ Hereditary diffuse gastric cancer (E-cadherin)
  ***Please contact the DNA Lab prior to sending the sample***
- ☐ Hereditary hemochromatosis (HFE)
- ☐ Hereditary pancreatitis
- ☐ Myotonic dystrophy Type 1
- ☐ Prader-Willi syndrome
- ☐ Rett syndrome
- ☐ Sickle cell/Hemoglobin C disease
- ☐ X chromosome inactivation
- ☐ Y micro-deletion study (male infertility)
- ☐ Other: _____
- ☐ Factor V (Leiden)
- ☐ Prothrombin 20210G>A
- ☐ Methylenetetrahydrofolate reductase (MTHFR) 677C>T
  - ☐ MTHFR 1298A>C

**Multiple Endorcrine Neoplasia (MEN), Type 2**

- ☐ Familial medullary thyroid carcinoma
- ☐ MEN 2A
- ☐ MEN 2B

**Physician Signature:**

**Send Reports To:**

Name (required):
HFH Dr. Code or NPI #:
Address:
Phone # (required):
Fax #:

Name:
HFH Dr. Code or NPI #:
Address:
Phone # :
Fax #:

**Lab use:** Sample Type:_____ Cultures:_____ Volume:_____ Date Received:_____

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