



Test Requisition Form

Patient Information

Name: _____

Sex of Patient: Male Female

Address: _____

Date of Birth: _____

City: _____ State: _____ Zip: _____

Social Security Number: _____

Phone: _____

MR#: _____

Referring Provider Information

Institution: _____

Address: _____

Contact Name: _____

Phone: _____ Fax: _____

I attest that this patient has been informed about and has given consent for the test(s) I have ordered below.

Referring Physician (sign) _____

(print) _____

Genetic Counselor (sign) _____

(print) _____

Clinical Information

Gravida: _____ Para: _____ SAB: _____ TAB: _____

EDC: _____ by LMP US IVF

Ultrasound Date: _____

NT (mm): _____ CRL(mm): _____

Final chromosome result (if available): _____

Procedure: _____ Procedure Date: _____

Other Applicable Clinical or Family History Information:

Test(s) Ordered

- Updated Increased Nuchal Translucency Testing Panel
- Skeletal Dysplasia Testing Panel
- Maternal Cell Contamination (*if requested, please provide one purple top tube of maternal blood*)

Specimen type:

- Preferred specimen types:*
- cultured chorionic villi
 - cultured amniocytes

- Please call ahead to inform us if you are sending one of the following:*
- direct chorionic villi
 - direct amniotic fluid
 - extracted DNA