SMT. GULABBEN RASIKLAL DOSHI & SMT. KAMLABEN MAFATLAL MEHTA

Institute of Kidney Disease & Research Centre

Dr. H. L. Trivedi Institute of Transplantation Science

Civil Hospital Campus, Asarwa, Ahmedabad – 380 016, Gujarat, India

DEPARTMENT OF OBSTETRICS AND GYNECOLOGY

CYTOGENETICS REQUISITION FORM

All Information Must Be Complete Before Sample Can Be Processed

PATIENT INFORMATION

Patient Name: _____, _____, _____
Last First Middle

MR#: _____ Date of Birth: ____ / ____ / ____ Gender: ☐ Male ☐ Female

Mother's Name: _____, _____, _____ Date of Birth: ____ / ____ / ____ Age: _____
Last First Middle

Father's Name: _____, _____, _____ Date of Birth: ____ / ____ / ____ Age: _____
Last First Middle

Address: _____, City: _____, State: _____, PIN: _____

Phone: (____) _____ Fax: (____) _____ Email: _____

SAMPLE / SPECIMEN INFORMATION

☐ Amniotic Fluid ☐ Product of Conception
☐ CVS ☐ Peripheral Blood
☐ Others _____ (specify)

Specimen Date: ____ / ____ / ____ Time: ____ : ____

Pregnancy Data for Prenatal Sample: (Multiple gestation - separate requisitions)
Ultrasound Date: ____ / ____ / ____
GA on US Date: ____ wks ____ days
LMP: ____ GA by LMP: ____ wks ____ days
G ____ P ____ SAB ____ TAB ____

REFERRING PHYSICIAN

Hospital Name: _____
Physician Name: _____
Address: _____
Phone: (____) _____ Fax: (____) _____
Email: _____
Genetic Counsellor / Lab Contact Name: _____
Phone: (____) _____ Fax: (____) _____
Email: _____
_____ Date: ____ / ____ / ____
Referring Physician Signature (REQUIRED)

LABORATORY TESTS ORDERED

☐ Chromosome Analysis'
  ☐ If chromosomes are normal. reflex to microarray - Parental samples recommended for Prenatal Microarray
☐ Prenatal Aneuploidy FISH Panel (FISH for 13. 18. 21, X and y)
☐ Microdeletion & Cryptic Translocation FISH Panel Velocardiofacial (DiGeorge) Syndrome (deletion 22q11.2) FISH
☐ SNP Microarray - Parental samples recommended for Prenatal Microarray

Parental Sample Information for Prenatal Microarray:
Maternal sample included
Paternal sample included
Father of fetus' name: _____ DOB: __/ __/__
Maternal sample not collected
Paternal sample not collected

INDICATIONS FOR DIAGNOSIS

☐ Abnormal maternal serum / first trimester screen. Increased risk of:
  ☐ NTD ☐ Down syndrome ☐ Trisomy 18
  ☐ Others (specify): _____
☐ Abnormal fetal ultrasound: _____
_____
☐ Recurrent Miscarriage
☐ Family History: _____
_____
☐ Advanced Maternal Age
☐ Infertility
☐ Consanguinity (please specify relationship): _____
_____
☐ Abnormal Sexual Development
☐ Other: _____

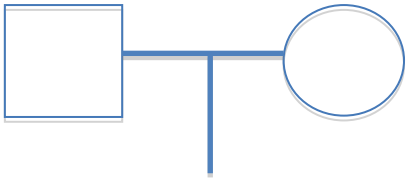
CONSENT FORM: Consent to carry out Chromosome Study on Chorionic Villi / Amniotic Fluid / Abortus Material / Bone Marrow / Blood

I/we give my/our consent to carry out Genetic Study at above mentioned facility, as a diagnostic test. I/We fully agree and understand that culture may fail due to any circumstances requiring recollection of the sample. I/we understand that even under normal circumstances sample's cells may not be able to grow making the genetics study difficult. I/We hereby agree to provide another sample if needed.
It is further agreed that the nature of this agreement is such that it must remain confidential and we agree that the sole copy of the agreement may be retained in by the above doctors file and shall not be disclosed except under unavoidable circumstances.

Date: _____ **Place:** _____ **Name (in block):** _____ **Signature:** _____

Witnesses: Name (in block): _____ Signature: _____ Name (in block): _____ Signature: _____

PEDIGREE



REPORT

Blood Counts:
Bone Marrow Counts:
Folate: B12: HCY:
TORCH: aPL: VDRL:
ANA:
USG Findings: NT: Nuchal Fold:
Triple Marker Results: AFP:
HCG:
UE_3:

Remarks / Notes:

INSTRUCTIONS FOR SAMPLING TISSUE FOR CYTOGENETIC ANALYSIS

Each specimen must be clearly labeled with patient name and birth date. Requisition must supply name, birth date, gender, physician, originating lab or clinic, and clinical indication. Overnight shipping is acceptable where necessary.

Peripheral Blood
5 – 10 cc blood in green top vaccutainer (Sodium Heparin) for adults and 1-2 cc for infants. Do not use lithium heparin or ammonium heparin. Mix well by inverting. Sample to be maintained at R.T. Samples should arrive within 48 hours (preferably 24 hours) of sampling.
Study time: 10 – 20 days.

Amniotic Fluid
15 – 20cc sterile amniotic fluid in two sterile screw-capped tubes (centrifuge tubes). First 2ml drawn should be discarded to reduce chance of maternal cell contamination. If prenatal interphase FISH is also desired, a minimum of 20ccs ofamniotic fluid is required. Label with (a) Patients name (b) Gestational Age (c) Doctor's Name (d) Date and time drawn. Specimen to be kept at R. T.
Study time: 14– 24 days.

Chorionic Villus Studies
This is studied at 10 – 13 weeks of pregnancy for various chromosomal & single gene disorders. Collect 15 to 20 mg of good quality chorionic tissue in the provided media in aseptic condition & send it to laboratory.
Study time: One week to 3 weeks depending on the type of investigation.

Product of conception-Fetal Tissue/Placenta
Selected tissue specimens should be obtained from abortus material. Preferred tissues are maternal cartilage, skin from the upper arm or thigh, fetal membranes, cord or placenta near cord attachment. In the case of an IUFD, send both fetal tissue(preferably toe tissue) and a specimen of placenta. Preferably collected in a tissue culture media(RPMI); if not available use Sterile Saline. Fill tube completely. Cap tightly and cover with parafilm. Refrigerate at 4-8°C until shipment (Do not freeze)
Study time : 3 – 4 weeks.

All samples are to be sent immediately to Cytogenetics Laboratory (Gynaec ward, 2nd floor, IKDRC). If sample delivery is delayed, please refrigerate but DO NOT FREEZE. Contact Cytogenetics Laboratory if there are any questions about sample collection. The Cytogenetics Lab should be notified before any tissue is sent for chromosome studies. Requisitions must be sent with all samples. Ph no. 22685600 Ext. 7111