AUCKLAND CITY HOSPITAL

Diagnostic Genetics Request Form

Lab PLUS
FORM CC6555

BAR CODE
Lab Use Only

Time Taken

Date Taken

Collector:

Family Name First Name

NHI Number Gender Date of Birth

Ward

AFFIX PATIENT LABEL

PLEASE INDICATE SAMPLES COLLECTED: Draw order CPD Heparin EDTA Other

Received Lab

Send Report to:

- ☐ Blood
- ☐ P.O.C.
- ☐ Bone Marrow
- ☐ Amniotic Fluid
- ☐ Cord Blood
- ☐ C.V.S.
- ☐ Tumour
- ☐ Paraffin Embedded tissue
- ☐ Skin
- ☐ Other ....

CYTOGENETICS

- ☐ Karyotype (Chromosomes)
- ☐ Molecular Karyotype (Microarray)
- ☐ FISH studies
  - ☐ Aneuscreen
  - ☐ Other *(specify type)* ☐ AFP

....

- ☐ Other *(please specify)*

....

☐ Pregnant Gestational Age *(weeks)* ....

Obstetric History G........ P........

DO PARENTS WISH TO KNOW SEX? ☐ Yes ☐ No

MOLECULAR GENETICS

- ☐ DNA extraction/storage
- ☐ Triplet repeat expansions
- ☐ Single gene analysis
  - ☐ Sequencing
  - ☐ Dosage
- ☐ Multiple gene analysis
  - ☐ Sequencing
  - ☐ Dosage
- ☐ Predictive/carrier testing (exon-specific)
- ☐ Sendaway Test
- ☐ Confidential

Specific Test(s)

Copy to:

Clinician Email Address:

MOLECULAR HAEMATOLOGY

☐ ***Specific Test(s)***

Supporting Clinical Information (including abnormalities noted on ultrasound)

Clinician Ordering Tests *Mobile/Locator Number:* .... *NZMC# or practitioner code#* ....

NAME IN BLOCK LETTERS .... Signature .... Date ....

JUNE 2017