

Clinical Genomics Laboratory
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SNP Array Virtual Karyotyping Requisition Account #980

***NOTE – Ship specimens via overnight delivery. Please ship Monday – Thursday. Avoid Friday afternoon or weekend delivery.**

I: Required Patient Information

Patient Full Name	Last _____ First _____ MI ____
Date of Birth-Month/Date/Year	
Gender	__Male __Female
Hospital/Clinic Name	
Patient Medical Record Number	
Date Collected-Month/Date/Year	
Time Collected	
Physician Name/HCP	
Physician/HCP Phone # including area code	
Physician/HCP Email Address	
Clinical Diagnosis/Indication for Testing	

(Internal Use Only. AP Easy Accession # _____)

II. SEND REPORTS TO:

Name _____

Fax (Secure) _____

Email (Secure) _____

III. BILLING INFORMATION :

Client Bill:

Account Name: _____

Address: _____ City/State/Zip _____

Phone: () _____ Fax: () _____

Contact Name: _____ Phone: _____ Email: _____

Patient Bill (Medicare only)

Patient Name _____

Insurance Carrier Name _____

Insurance Co. Address _____ Phone () _____

Guarantor Name _____ Date of Birth _____ SS# _____

Copy of insurance card **must** be included.

IV. SPECIMEN TYPE Attach a surgical pathology report or hematopathology report for each specimen sent. Ship specimens via overnight delivery. Please ship Monday – Thursday. Avoid Friday afternoon or weekend delivery.

Specimen Type	Quantity
Blood, 1-5mL in EDTA (purple top) Ship at room temperature.	
Leukemic blood, 1-5mL in EDTA (purple top), WBC _____ Ship at room temperature.	
Bone marrow, 1-5mL in EDTA (purple top), WBC _____, ship at room temperature.	
Buccal cells, 2 swabs Ship at room temperature.	
Fresh tissue, ____mg; ____cm x ____cm x ____cm Ship on dry ice	
Paraffin embedded tissue block Tissue type _____	
Paraffin embedded tissue slides, ten 10um unstained slides with 1 H&E slide Tissue type _____	
Extracted DNA, >500ng Ship at room temperature	