THE UNIVERSITY OF ALABAMA AT BIRMINGHAM

Department of Genetics
Cytogenetics Laboratory
720 20th Street South, Room 314
Birmingham, Alabama 35294-0024
Phone: (205) 934-9555
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12/20/16

Medical Record # _____

PATIENT HISTORY AND REQUEST FORM FOR TISSUE CYTOGENETIC ANALYSIS

Patient Name: _____ Date of Birth: _____

Address: _____ Race: _____

_____ Sex: _____

Phone: ( ) _____

Requesting Physician: _____ Phone: ( ) _____

Fax: ( ) _____

Bill to: ☐ Hospital ☐ Insurance ☐ Patient

Address: _____ Phone: _____

_____ FAX: _____

_____

Insurance Company: _____ Policy No: _____

Group No: _____

Reason for study: _____

Gestational age: _____
(if applicable)

Type of specimen: _____ (i.e. chorionic villus, skin biopsy, foreskin, etc)

Specimen collected: Date: _____

Time: _____

Studies requested

Chromosome analysis: _____

FISH tissue aneuscreen: _____ Screens for numerical abnormalities of chromosomes X,Y,13,15,16,18, and 21

aCGH+SNP analysis: _____

Please call (205) 934-9570 if you have any questions.