Date: January 2002

CYTOGENETICS LABORATORY REQUISITION

SHIPPING ADDRESS:
Dr. Arleen D. Auerbach
The Rockefeller University
1230 York Ave.
New York, NY 10021
(212) 327-8862, (212) 327-8262 FAX

TEST REQUESTED: CHROMOSOME BREAKAGE DIEPOXYBUTANE (DEB) TO RULE OUT FANCONI ANEMIA

PATIENT NAME:_____________________________________ HOSPITAL NO.__________

BIRTHDATE:____

sex:_______ height:________ weight:______

REFERRING PHYSICIAN:_____________________________

PHYSICIAN'S TELEPHONE #: area code (____)________________________

Peripheral blood in sodium heparin (______) amount(_____) cc.

date drawn ___________ time (______) WBC (______)

PRECAUTIONS____

Clinical Diagnosis:____

Indication for study:

____

Please circle if appropriate:

ABNORMALITIES

thumb and radius
other skeletal
cafe au lait spots
kidney
genital
urinary tract
cardiac
eye, microphthalmia
GI
growth retardation
ear,deafness
learning disabilities

aplastic anemia
age of onset_____
sibling of FA patient
parent of FA patient

OTHER____

I have informed the patient that this is a genetic test and that the results of this test could have implications for his or her family. If the test is positive, genetic counseling will be recommended.

SIGNATURE OF PERSON ORDERING THE TEST_________________________________**DATE:**_________
(test will not be performed in the absence of a signature and date)

NAME, ADDRESS, TELEPHONE AND FAX NUMBERS OF INDIVIDUAL WHO IS TO RECEIVE TEST RESULT, AND INDIVIDUAL RESPONSIBLE FOR PAYMENT OF THE INVOICE.

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