CARDIOVASCULAR DISEASES GENETIC TESTING - PRENATAL SAMPLE REQUISITION

(Must be completed in addition to the individual Test Requisition)

Patient label	**Molecular Genetics Laboratory**, Cincinnati Children's 3333 Burnet Avenue, Room NRB 1013 Cincinnati, OH 45229 Phone: 513-636-4474 Fax: 513-636-4373

PATIENT INFORMATION

First Name_____ MI _____ Last Name_____

DOB _____ Street Address _____

City, State, Zip Code _____

Fetal Specimen type: (MM/DD/YYYY)

☐ Amniotic Fluid ☐ Chorionic Villi ☐ Cultured Cells Date Collected _____
☐ Other_____

Maternal Specimen type: (MM/DD/YYYY)

☐ Blood ☐ Buccal swab (X2) ☐ Other _____ Date Collected _____

SAMPLE REQUIREMENTS

AMNIOTIC FLUID	**Chorionic Villi**
Amniotic Fluid – 20mL Maternal sample – 3mL blood in EDTA Lavender top tube OR 2 buccal swabs	Chorionic Villi – 30+mg Maternal sample – 3mL blood in EDTA Lavender top tube OR 2 buccal swabs

TEST TO BE PERFORMED

GENE TEST TO BE PERFORMED_____
(Individual gene test requisition must be included)
Is this a known mutation – Yes / No If yes, what is the known mutation_____

☐ Amniotic Fluid (Requires cell culture and maternal cell contamination studies)
☐ Chorionic Villi (Requires cell culture and maternal cell contamination studies)
☐ Cultured cells (Requires maternal cell contamination studies)

Ordering Physician's signature____ _____Date_____
(Required)

Please note:

- Please call 513-636-4474 to discuss prenatal testing with a genetic counselor prior to shipment
- Turnaround time is for specific test ordered, however prenatal samples are given priority
- If you are sending prenatal cells in culture, make sure that your institution keeps a back-up culture
- For samples that will arrive on Saturday, please call laboratory at 513-636-4474 to inform