CYTOGENETICS ANALYSIS
Cytogenetic Laboratory
Laboratory Medicine

MUST BE COMPLETED IN FULL or ADDRESSOGRAPH (if available)

☐CHROMOSOME STUDY
☐OTHER ____________________
(Please Specify)

Patient Name:_____________________________________ Sex: ☐ Male ☐ Female

Address: ____

DOB: (dd/mm/yy)____________________ Phone (Home/Work)___________________

P.H.N.#:__________________________ RUH#: ___________________________

Ref. Doctor / Family Doctor: _____________________________ Phone:_____________

Geneticist: ____

SPECIMEN: ☐ BLOOD ☐ BONE MARROW ☐ SKIN
☐ OTHER __________________________________
(Please specify)
Date Collected___________________________

Indication/Reason for Cytogenetic Analysis: ___________________________________
____
Comments/ Special Instructions: ____
Signature: ____

SAMPLES MUST BE BOOKED IN ADVANCE WITH THE CYTOGENETICS LABORATORY BY CALLING (306) 655-1706

For blood 2 to 7 mls in a **SODIUM** heparin (green) tube is required.

Label each package "FOR THE GENETICS LABORATORY 655-1706". Please ensure that samples are well insulated to avoid extremes of temperature during transit.

Room #35, ELLIS HALL ROYAL UNIVERSITY HOSPITAL SASKATOON, SK S7N 0W8 655-1706

Form# 101431 (03/06)