Health Sciences Centre

Request for Tissue Biopsy Culture

Cytogenetics Laboratory
Health Sciences Centre

Patient Name: _____ **DOB (d-m-y)** _____ / _____ / _____
Last **First**

Geneticist: _____ **Date of Request:** _____

Clinical Indication: _____

_____

_____

SPECIMEN TYPE:

☐ **New Sample**

☐ **Previously Frozen / Stored**

SCHEDULING INFORMATION:

☐ **For Specimens to be taken during Surgery.**

Date of Surgery: _____

☐ **For specimens to be taken by biopsy, please provide contact information so lab can call to arrange a suitable date.**

TEST(S) REQUIRED:

☐ **Chromosome Analysis**

☐ **Freeze / Store**

☐ **Culture for Metabolic Testing to be sent to:**

Name: _____
Address: _____
_____
_____
Phone: _____
Fax: _____
Email:

Letter attached ☐

Letter to follow ☐

Contact Name: _____ **Contact Phone:** _____

Lab Use Only

Date of Biopsy Culture

☐ **Confirmed Date:** _____

☐ **TBA**

Approved by: _____ _____
(Director or Designate) **Date**

The Cytogenetics Laboratory will attempt to adhere to the schedule for all confirmed biopsy culture dates. However, there may be instances where, due to circumstances beyond our control, such as a high number of samples or POCs, confirmed dates may have to be rescheduled. We thank you in advance for your understanding.