

Date: April 2003

**CYTOGENETICS LABORATORY REQUISITION**

**SHIPPING ADDRESS:**

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

*Please return with blood sample.*

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

aplastic anemia

thumb and radius

other skeletal

age of onset \_\_\_\_\_

cafe au lait spots

kidney

sibling of FA patient

genital

urinary tract

parent of FA patient

cardiac

eye, microphthalmia

GI

growth retardation

ear, deafness

learning disabilities

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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