

Constitutional Blood Test Request

Karyotype / Chromosome / Cytogenetic Analysis

GeneCode Healthcare, LLC 1350 Pear Ave, Suite B Mountain View, CA 94043 Phone: 650-537-4091 www.genecodehc.com

Contact laboratory at 650-537-4091 or email genecode@genecodehc.com for questions regarding test appropriateness

Patient	Provider
Name (last, first):	Ordering Provider:
Patient Address:	Provider Address:
City/State/Zip:	City/State/Zip:
Patient's Phone:	Provider's Phone:
Date of Birth (MM/DD/YY):	Provider's Fax:
Sex Assigned at Birth: ☐ Female ☐ Male ☐ Intersex	Genetic Counselor:
Gender Identity (optional): ☐ Female ☐ Male ☐	Counselor's Phone:
Clinical Indications / DIAGNOSTIC CODE(S) /	Check all that apply:
Family History, if appropriate:	□ Infertility
, , , , ,	☐ Recurrent miscarriage
	☐ Partner with recurrent miscarriage
	(partner's name):
	☐ Congenital anomalies
	(specify):
	☐ Intellectual and/or developmental disability
	☐ Autism / Autism spectrum disorder
	□ Ambiguous genitalia
	Suspected diagnosis of:
	□ Down Syndrome □ Trisomy 18 □ Trisomy 13
	□ Turner syndrome
	Previous abnormal prenatal cfDNA screening (NIPS):
	□ T21 □ T18 □ T13 □ Turner syndrome
	□ XXX □ XXY □ XYY □ Other:
Sample Type: Peripheral Blood Cord Blood	
Turnaround time required: ☐ Routine ☐ STAT (newborn)	
Sample Collection – ONLY sodium heparin green top tube accepted (minimum volume required is 1 ml)	
Collection Date:	
Collection Time:	
Drawn By:	
SHIP AT ROOM TEMP via medical courier to:	
GeneCode	
1350 Pear Ave, Ste B	
Mountain View, CA 94043	
PHYSICIAN SIGNATURE:	DATE:

