



Molecular Diagnostics Laboratory  
 Department of Pathology and Laboratory Medicine  
**CYTOGENETICS AND MOLECULAR  
 DIAGNOSTICS TEST REQUEST**

**Instruction:**

To be completed by ordering provider and sent with the specimen to Molecular Diagnostic Lab (room L849). Specimen must be in the Molecular Lab by 4:00pm Monday-Friday.  
**Please note this form is intended only for tests listed in boxes below.** Contact the lab at 302-733-3530 with any questions. Other forms that may be required include:  
 - Surgical Pathology and Genetics Request Form for Products of Conception and Fetal Demise (#24484)  
 - Hematology/Oncology GenPath Diagnostics Requisition for Blood or Bone Marrow (#24760)

**1. Required information (test may be canceled or results delayed if this section is not filled out):**

Diagnosis: \_\_\_\_\_

Specimen collected by: \_\_\_\_\_

Birth sex:  Male  Female

Collection date: \_\_\_\_/\_\_\_\_/\_\_\_\_ /time: \_\_\_\_\_

**2. Specimen type:**  Peripheral blood  Other: \_\_\_\_\_

**3. Test Requested:**

PCR tests, listed below – lavender or cobas tube	FISH/Chromosome tests, listed below – green tube
<input type="checkbox"/> <b>FV: Leiden</b> <span style="margin-left: 100px;"><input type="checkbox"/> <b>Prothrombin 20210</b></span> <input type="checkbox"/> <b>Cystic Fibrosis Mutation</b>  <input type="checkbox"/> <b>Chlamydia/Gonorrhea (cobas tube)</b> <input type="checkbox"/> <b>Trichomonas/M. genitalium (cobas tube)</b>  *Infectious Disease Tests listed below require plasma, poured over and frozen within 6 hours of collection* <input type="checkbox"/> <b>HIV Quant</b> <span style="margin-left: 100px;"><input type="checkbox"/> <b>HIV Genotype</b></span> <input type="checkbox"/> <b>HIV Integrase Genotype</b> <input type="checkbox"/> <b>CMV Quant</b> <input type="checkbox"/> <b>HBV Quant</b> <span style="margin-left: 100px;"><input type="checkbox"/> <b>HBV Genotype</b></span> <input type="checkbox"/> <b>HCV Quant</b> <span style="margin-left: 100px;"><input type="checkbox"/> <b>HCV Genotype</b></span> <input type="checkbox"/> <b>Other (be specific):</b> _____	<p style="text-align: center;"><b>**Choose one**</b></p> <p><b>**Requests for Chromosome Analysis and SNP Microarray together must be approved by the Molecular Diagnostics Laboratory BEFORE ordering</b></p> <input type="checkbox"/> <b>Chromosome Analysis (Blood only)</b>  <input type="checkbox"/> <b>SNP Microarray (Blood only)</b>  <input type="checkbox"/> <b>Other (be specific):</b> _____

**Ordered by:**

\_\_\_\_\_

Ordering Physician Signature/Title \_\_\_\_\_ Print Name or ID# \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Time \_\_\_\_\_