Eastern Health
Clinical Cytogenetics Laboratory

Cytogenetics Requisition for Amniocentesis

Phone:(709) 777-4532
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CL1690 1193 02 2015

Name:

HCN:

Date of Birth:

Cytogenetics Laboratory Number: _____

Referring Physician:

_____
Print Name

_____
Signature

Referring Institution: _____

Submission Date: _____ DD/MONTH/YYYY

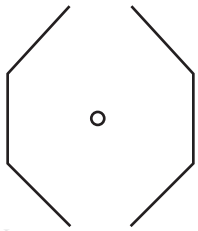
Phone: _____ Fax: _____

Copies of report to:

1. Name (print): _____
   Address: _____
   _____
   Phone: _____ Fax: _____
2. Name (print): _____
   Address: _____
   _____
   Phone: _____ Fax: _____

Reason for Cytogenetic study:

Physician performing procedure: _____



Gestational age: _____

Date of procedure: _____ DD/MONTH/YYYY

LMP: _____

EDC: _____

Procedure notes:

	First insertion	Second insertion
Number of needle insertions		
Amount of fluid (ml)		
Colour of fluid	☐ Clear ☐ Cloudy ☐ Bloody	☐ Clear ☐ Cloudy ☐ Bloody
Placenta avoided?	☐ Yes ☐ No	☐ Yes ☐ No

Ultrasound findings and comments: