



## **CONSTITUTIONAL LABORATORY REQUEST FORM**

Patient Details					1	Sample Requirements		
NHI:		D.O.B:						
Surname:		Sex:	F	/ M		Lithium Heparin Blood (2 -5 mL)		
First Name/s:		DHB of Domicile:				Date & Time of Colle	ction:	
Requested by:		Date:				Reference Numb	er	
C&SRGS #		Lab File #						
				UF	RGEN	Т		
				RC	DUTIN	IE		
Reason for Referral and Test required (please give details)								
		KARYOTYI	PE [	]				
		FISH	C	]				
N.B. For microarray or molecular referrals please use specific referral and consent form available on www.wellingtongenetics.co.nz								

## Consent

In submitting this sample the referring clinician confirms that patient consent has been obtained for genetic testing and storage.

 Wellington Regional Genetics Laboratory

 Title:
 798.5 Constitutional Karyotype and FISH Request Form
 Manual: Fo

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 Written by: Rachel Beddow
 Authorised

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