WAKE FOREST UNIVERSITY MEDICAL GENETIC LABORATORIES
Department of Pediatrics, Medical Center Blvd., Winston-Salem NC

Physician Request for Additional Cytogenetic Testing

Physician: _____ **Date:** _____

Patient: _____ **Lab Number:** _____

Test requested: _____ **Date:** _____

Preliminary cytogenetic results and/or requests from the referring physician(s), it is recommended that additional cytogenetic testing be performed to complete the analysis. The recommended test(s) are:

CPT code _____

[ ] 88233 Tissue culture and processing of cells for send-out testing

[ ] 88240 Cryopreservation, freezing and storage of cells, each cells line

[ ] 88241 Thawing and expansion of frozen cells, each aliquot

[ ] 88261 Chromosome analysis; count 5 cells, 1 karyotype, with banding

[ ] 88262 Count 15-20 cells, 2 karyotypes, with banding

[ ] 88263 Count 45 cells for mosaicism, 2 karyotypes, with banding

[ ] 88264 Analyze 20-25 cells

[ ] 88280 Chromosome analysis; additional karyotypes, each analysis

[ ] 88283 Additional specialized banding technique (eg, NOR, C-banding)

[ ] 88285 Additional cells counted, each study

[ ] 88289 Additional High resolution study

[ ] **Other:** _____

Upon your approval, we will proceed with the necessary testing

Physician approval signature: _____ Date: _____

Verbal approval by: _____ Date: _____

Laboratory Director/Supervisor: _____ Date: _____

Please FAX your reply to 336-716-2554 asap (within 1 week of the above date)

If you have any questions please call 336-716-4321 *Thank you for your assistance.*