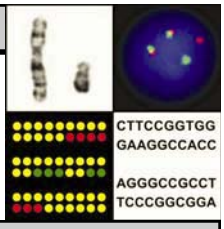
UW Cytogenetic Services—WSLH Postnatal Chromosome Microarray Testing



Instructions: The accurate interpretation and reporting of genetic test results is contingent upon the reason for referral, clinical information provided, and family history. To help provide the best possible service, please check the applicable clinical information below. **Please send this page with the specimen or return by fax to the WSLH Cytogenetics Laboratory (fax: 608-265-7818) . If a karyotype has been performed, please note the results at the bottom of the form.**

Patient Identification

Patient Identification
Patient Name: _____ (Last) _____ (First) **Gender: [ ]** Male **[ ]** Female
Date of Birth: _____ (mm/dd/yyyy) **Date of Collection: _____**

Clinical Information — Check all that apply. Use additional space at the bottom of the form if needed.

Perinatal History
[ ] Prematurity
[ ] Intrauterine growth restriction
[ ] Oligohydramnios
[ ] Polyhydramnios
[ ] Non-immune hydrops fetalis
[ ] Other: _____

Growth
[ ] Failure to thrive
[ ] Overgrowth
[ ] Short stature
[ ] Other: _____

Cognitive/Developmental
[ ] Learning disability
[ ] Developmental delay
  [ ] Gross motor delay
  [ ] Fine motor delay
  [ ] Speech delay
[ ] Intellectual disability/MR
[ ] Other: _____

Behavioral/Psychiatric
[ ] Autism
[ ] Pervasive developmental delay
[ ] Attention deficit hyperactivity disorder
[ ] Anxiety
[ ] Behavioral/psychiatric abnormality
  Specify: _____
[ ] Other: _____

Cutaneous
[ ] Hyperpigmentation
[ ] Hypopigmentation
[ ] Other: _____

Neurological
[ ] Seizures
[ ] Hypotonia
[ ] Hypertonia
[ ] Cerebral palsy
[ ] Encephalopathy
[ ] Structural brain anomaly
  Specify: _____
[ ] Other: _____

Cardiac
[ ] Atrial septal defect
[ ] Ventricular septal defect
[ ] Coarctation of the aorta
[ ] Tetralogy of Fallot
[ ] Other structural heart defect
  Specify: _____
[ ] Other cardiac abnormality
  Specify: _____

Craniofacial
[ ] Dysmorphic facial features
  Specify: _____
[ ] Ear malformation
  Specify: _____
[ ] Cleft lip
[ ] Cleft palate
[ ] Macrocephaly
[ ] Microcephaly
[ ] Other: _____

Hearing/Vision
[ ] Hearing loss
  Specify: _____
[ ] Abnormality of Vision
  Specify: _____
[ ] Abnormality of Eye Movement
  Specify: _____
[ ] Other: _____

Musculoskeletal
[ ] Contractures
[ ] Club foot
[ ] Diaphragmatic hernia
[ ] Limb anomaly
  Specify: _____
[ ] Polydactyly
  Specify: _____
[ ] Syndactyly
  Specify: _____
[ ] Vertebral anomaly
  Specify: _____
[ ] Other: _____

Gastrointestinal
[ ] Gastroschisis
[ ] Omphalocele
[ ] Anal atresia
[ ] Tracheoesophageal fistula
[ ] Pyloric stenosis
[ ] Other: _____

Genitourinary
[ ] Ambiguous genitalia
[ ] Hydronephrosis
[ ] Kidney malformation
  Specify: _____
[ ] Cryptorchidism
[ ] Hypospadias
[ ] Other: _____

Family Hi story
[ ] Parents with ≥ 2 miscarriages
[ ] Other relatives with similar clinical history
  Explain: _____
_____
_____
_____

Please include any additional information not provided above (list karyotype if known).

As a participant in the ICCG (International Collaboration for Clinical Genomics) Consortium, the WSLH Cytogenetics Laboratory contributes submitted clinical information and test results to a HIPAA compliant, de-identified public database as part of the NIH's effort to improve understanding of the relationship between genetic changes and clinical symptoms. Confidentiality is maintained. Patients may request to opt-out of this scientific effort by: 1) checking the box below, 2) calling the laboratory at **608-262-0402** and asking to speak with a genetic counselor, or 3) visiting our website at http://slh.wisc.edu/cytogenetics.
[ ] Indicate refusal for inclusion in these efforts by checking this box. If the box is not marked, data will be anonymized and used.