



**Requesting physician:**

**Patient information:**

### Request Form Postnatal diagnostics

**Postnatal tests:**

- Microscopic chromosome analysis**
- Array CGH analysis\***
- FISH for specific chromosome / region:**  
please specify: \_\_\_\_\_
- DNA analysis**  
Please specify gene(s):  
\_\_\_\_\_  
\_\_\_\_\_

**Indication / Diagnosis:**

- Developmental delay
- Dysmorphic features / malformations
- Growth retardation
- Recurrent fetal loss
- Infertility
- Genetic disease: patient affected (diagnostic testing)
- Genetic disease: family member affected (predictive testing), please indicate family specific mutation:  
\_\_\_\_\_
- current pregnancy: week \_\_\_\_\_

\* Array CGH analysis performed by a collaborative laboratory

**Clinical information:**

**Date / Time of sampling:**

**Signature:**

**Specimen requirements and logistics:**

- **Patient Consent Form for Genetic Testing according to the German Law and Request Form**
- **Billing information (Insurance-, Institutional- or Selfpay-Billing)**
- **for chromosome / FISH analysis: 3 mL heparinised blood**
- **for DNA analysis: 5 mL EDTA blood**