

330 Brookline Ave, Boston, MA 02215

| Beth Israel Deaconess Medical Center Cytogenetics Laboratory For Fanconi Anemia Testing | |
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| Website: https://www.bidmc.org/centers-and-departments/pathology | |

FANCONI ANEMIA- CHROMOSOME BREAKAGE TEST REQUISITION FORM

| <u>Please Print</u> | <u>Specimen Information</u> |
|---|--|
| Patient name _____ | Sample Collection Date: _____ |
| Date of Birth: _____ | Sample Type: Blood ____ Fibroblast Culture ____ |
| Sex: M ____ F ____ Other ____ | WBC count: _____ |
| ICD10 code _____ | <u>Clinical Information</u> |
| Diagnosis: _____ | Check all that apply and specify: |
| Referring Physician _____ | <input type="checkbox"/> Cancer diagnosis |
| NPI# _____ | <input type="checkbox"/> Chemotherapy (last 6 months) |
| Department _____ | <input type="checkbox"/> Family member with suspected or confirmed Fanconi Anemia, relationship _____ |
| Phone _____ | <input type="checkbox"/> Family history of breast cancer, relationship _____ |
| Signature _____ | <input type="checkbox"/> Family history of BRCA mutation, relationship _____ |
| <u>Hospital Billing Information:</u> | <input type="checkbox"/> Skeletal abnormality, specify: _____ |
| Name _____ | <input type="checkbox"/> Dysmorphic features _____ |
| Address _____ | <input type="checkbox"/> Gastrointestinal malformations specify _____ |
| Billing Fax#/email _____ | <input type="checkbox"/> Eye abnormalities _____ |
| Result Fax# _____ | <input type="checkbox"/> Urogenital abnormalities _____ |

Laboratory Use Only

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| Mailing Address: Attn: Cytogenetics Lab – Fanconi Anemia Beth Israel Deaconess Medical Center Lab Control, Finard Rm 305 330 Brookline Ave. Boston MA 02215 | BIDMC Medical Record # _____ BIDMC Lab Accession # _____ |
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