Chromosomal Microarray Test (CMA Test)

Medical Referral Form

Paitient Information (Required)				
First Name			Last Name	
Date of Birth (MM/DD/YYYY)			Sex	☐ Male ☐ Female
Ancestry	☐ White/Caucasian	☐ Ashkenazi Jewish	☐ Black/African American	☐ Native American
	☐ Asian	☐ Hispanic	☐ Pacific Islander	☐ Other:
Sample Information (Required)				
Sample Collection Date (MM/DD/YYYY)				
Specimen	☐ Blood (EDTA)		☐ DNA	
Ordering Physician Information (Required)				
First Name			Last Name	
Email Address			Institution/Practice Name	
Phone #			Fax #	

※Please indicate the below clinical aspects of patient [√]

Perinatal History	Neurological	Musculoskeletal
☐ Prematurity	☐ Ataxia / dystonia / chorea	☐ Contractures
☐ IUGR	☐ Hypotonia	☐ Club foot
☐ Oligohydramnios	☐ Neural tube defect	☐ Diaphragmatic hernia
☐ Polyhydramnios	☐ Seizures	☐ Limb anomaly
☐ Other :	☐ Spasticity	☐ Polydactyly
	☐ Structural brain anomaly	☐ Scoliosis
Growth	☐ Other :	☐ Syndactyly
☐ Failure to thrive		☐ Vertebral anomaly
☐ Overgrowth	**Cardiac**	☐ Other :
☐ Short stature	☐ ASD	
☐ Other :	☐ AV canal defect	**Gastrointestinal**
	☐ Coartation of aorta	☐ Gastroschisis
Behavioral	☐ Hypoplastic left heart	☐ Hirschsprung disease
☐ Asperger syndrome features	☐ Tetralogy of Fallot	☐ Omphalocele
☐ Autism	☐ VSD	☐ Pyloric stenosis
☐ Oppositional-defiant disorder	☐ Other :	☐ Tracheoesophageal fistula
☐ Obsessive-compulsive disorder		☐ Other :
☐ Pervasive developmemtal delay	**Development**	
☐ Other :	☐ Fine motor delay	**Genitourinary**
	☐ Gross motor delay	☐ Ambiguous genitalia
Craniofacial	☐ Speech delay	☐ Hydronephrosis
☐ Cleft lip +/- cleft palate	☐ Other :	☐ Hypospadias
☐ Cleft palate alone		☐ Kidney malformation
☐ Coloboma	**Cognitive**	☐ Undescended testis
☐ Craniosynostosis	☐ Learning disability	☐ Urethra / ureter obstruction
☐ Dysmorphic facial features	☐ Mental retardation	☐ Other :
☐ Ear malformation	List IQ/DQ, if known :	
☐ Macrocephaly		**Family History**
☐ Microcephaly	**Cutaneous**	☐ Parents with ≥ 2 miscarriages
List HC, if known :	☐ Hyperpigmentation	☐ Ohter relatives with similar clinical history
☐ Other :	☐ Hypopigmentation	(explain below)
	☐ Other :	☐ Neonatal screening

※Please include any additional clinical history.

GC Genome

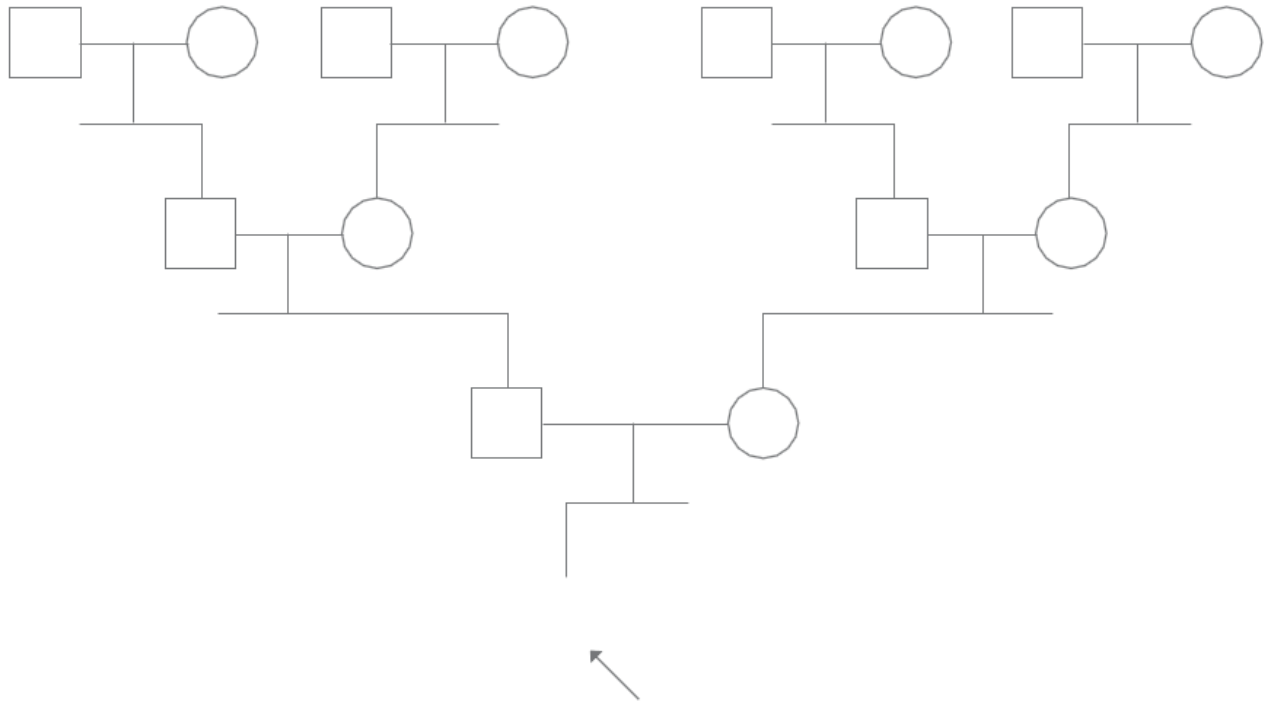
Chromosomal Microarray Test (CMA Test)

Medical Referral Form

Paitient Information	
First Name	Last Name
Date of Birth (MM/DD/YYYY)	

FAMILY PEDIGREE CHART

Ancestry



STANDARD PEDIGREE NOMENCLATURE

- Male
- Female
- Sex unspecified
- Adoption
- Pregnancy
- Deceased
- Affected with trait
- Birth order
- Divorce
- Abortion
- Dizygotic twins
- Monozygotic twins
- Autosomal dominant inheritance carrier
- Autosomal recessive inheritance carrier
- Marriage
- Consanguinity marriage
- Sibling
- No children
- Proband
- Remarriage

GC Genome