

**Form A  
Clinical Submission**

## Chromosome Microarray Analysis

### Patient Details

First name: \_\_\_\_\_ Last name: \_\_\_\_\_

Date of Birth: \_\_/\_\_/\_\_\_\_ Gender: Female  Male  Unknown

### Patient Clinical Information

\*Developmental delay, intellectual disability, autism, or at least two congenital abnormalities are required for Medicare benefit

* Developmental delay:	*Intellectual disability:
*Autism:	*Congenital abnormalities:
Congenital heart disease:	Dysmorphic features:
Other medical conditions:	Family History:
Suspected syndrome(s):	Previous Cytogenetics: (Attach report if possible)

### Clinical Information Check List

(please tick those that apply)

#### General:

- Developmental Delay
- ADHD
- Autism
- Intrauterine growth retardation
- Failure to thrive
- Short stature
- Other

#### Skeletal:

- Polydactyly
- Syndactyly
- Other digit anomalies
- Rib anomalies
- Scoliosis
- Club foot
- Other

#### Head and Eyes:

- Cleft lip/palate
- Macrocephaly
- Microcephaly
- Aniridia
- Cataract
- Other

#### Neurological:

- Seizures
- Holoprosencephaly
- Hypotonia
- Hypertonia
- Lissencephaly
- Agenesis of the corpus callosum
- Other

#### Uro-Genital:

- Ambiguous genitalia
- Horseshoe kidney
- Hydronephrosis
- Hypospadias
- Renal agenesis
- Other

#### Other:

- Biliary atresia
- Chondal atresia
- Congenital diaphragmatic hernia
- Tracheosophageal fistula

### Check list for submitting samples

<input type="checkbox"/> Clinical details completed	<input type="checkbox"/> Parent blood samples if provided (EDTA & Heparin)
<input type="checkbox"/> Signed Form B Patient Consent	Mother's name: _____
<input type="checkbox"/> Patient blood sample (EDTA tube)	Father's name: _____
<input type="checkbox"/> Patient blood sample (Heparin tube)	