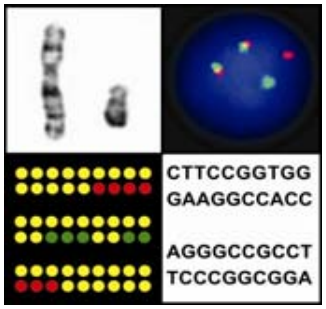


UW Cytogenetic Services

Wisconsin State Laboratory of Hygiene

Winter 2016

Test Menu Update:
Comprehensive Prenatal/Neonatal Microarray Analysis

The UW Cytogenetic Laboratory offers two prenatal microarray testing options:

890PREC: Comprehensive Prenatal/Neonatal Microarray Analysis

890PRET: Targeted Prenatal Microarray Analysis

Effective immediately, we are modifying our Comprehensive Prenatal Microarray Analysis test (890PREC) to include neonatal blood specimens. This updated test will now be known as 'Comprehensive Prenatal/Neonatal Microarray Analysis' and can still be ordered using test code 890PREC.

Recommended Uses:

Prenatal: The American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine recommend the use of chromosomal microarray analysis "in patients with a fetus with one or more major structural abnormalities identified on ultrasonographic examination and who are undergoing invasive prenatal diagnosis" and "in cases of intrauterine fetal demise or stillbirth when further cytogenetic analysis is desired."

Neonatal (less than 30 days of age or infants requiring intensive care): The American College of Medical Genetics and Genomics (ACMGG) has recommended that array comparative genomic hybridization (aCGH) is used as a first-line test in the evaluation of individuals with multiple congenital anomalies, non-syndromic intellectual and developmental disability, and autism spectrum disorders. SNP Array Comparative Genomic Hybridization is used to detect large regions of homozygosity as well as gains and losses of DNA from specimens containing high quality genomic DNA.

Turnaround Time: 7-10 days

Specimen Requirements:

Prenatal
Amniotic fluid (AF): 15-25 ml
Chorionic villus (CVS): 10-30 mg tissue.
Products of conception (POC): minimum 0.3 cm cubed fresh tissue. Placental villus is the preferred tissue; kidney, lung, and/or fascia are also acceptable.
FFPE tissue or frozen tissue: The cytogenetics laboratory will attempt to work with the specimen received and will return any unused material.
Cultured cells: 3-T25 flasks, 70% confluent.

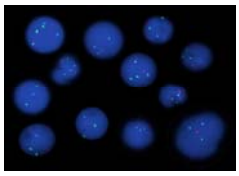
Neonatal
Blood: 2 ml in Sodium Heparin is recommended

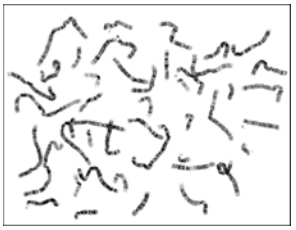
Please call our laboratory at 608-262-0402 with any questions.

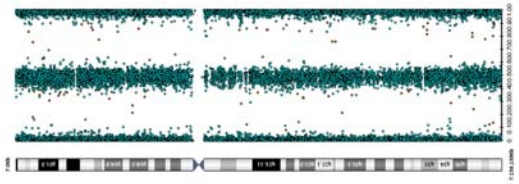
UW Cytogenetic Services

465 Henry Mall
Madison, WI 543705

Phone: 608-262-0402
Fax: 608-265-7818
www.slh.wisc.edu/cytogenetics







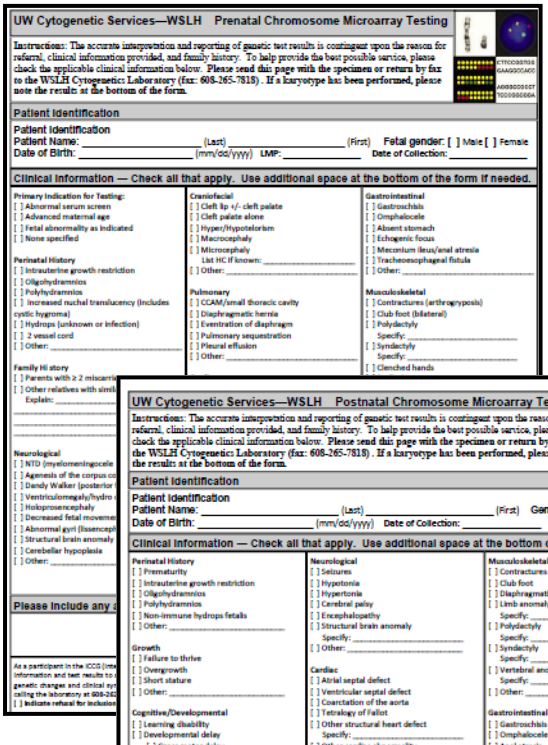
Please submit completed Phenotype Forms!

Complete and precise clinical patient information is critical for accurate and timely microarray interpretation.

Microarray requests are often submitted with generic diagnosis codes and/or clinical information. When copy number variation and/or large regions of homozygosity are identified, our interpretation of those findings can largely depend on the clinical information we are provided.

The UW Cytogenetic and Molecular Laboratories request phenotype data collection forms be submitted with all prenatal and postnatal microarray test requests. Forms can be found on our website under the "Forms and Resources" section at http://www.slh.wisc.edu/clinical/cytogenetics.

Completed forms should be returned to the UW Cytogenetics Laboratory directly with the patient sample or via fax (608-262-7818).



UW Cytogenetic Services—WSLH Prenatal 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) Fetal gender: [ ] Male [ ] Female
Date of Birth: _____ (mm/dd/yyyy) LMP: _____ Date of Collection: _____

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

Primary Indication for Testing:
[ ] Abnormal serum screen
[ ] Advanced maternal age
[ ] Fetal abnormality as indicated
[ ] None specified

Perinatal History
[ ] Intrauterine growth restriction
[ ] Oligohydramnios
[ ] Polyhydramnios
[ ] Increased nuchal translucency (includes cystic hygroma)
[ ] Hydrops (unknown or infection)
[ ] 2 vessel cord
[ ] Other: _____

Family Hi story
[ ] Parents with ≥ 2 miscarri
[ ] Other relatives with simil
Explain: _____

Neurological
[ ] NTD (myelomeningocele
[ ] Agenesis of the corpus ca
[ ] Dandy Walker (posterior
[ ] Ventriculomegaly/hydro
[ ] Holoprosencephaly
[ ] Decreased fetal moveme
[ ] Abnormal gyri (lissenceph
[ ] Structural brain anomaly
[ ] Cerebellar hypoplasia
[ ] Other: _____

Craniofacial
[ ] Cleft lip +/- cleft palate
[ ] Cleft palate alone
[ ] Hyper/Hypotelorism
[ ] Macrocephaly
[ ] Microcephaly
List HC if known: _____
[ ] Other: _____

Pulmonary
[ ] CCAM/small thoracic cavity
[ ] Diaphragmatic hernia
[ ] Eventration of diaphragm
[ ] Pulmonary sequestration
[ ] Pleural effusion
[ ] Other: _____

Gastrointestinal
[ ] Gastroschisis
[ ] Omphalocele
[ ] Absent stomach
[ ] Echogenic focus
[ ] Meconium ileus/anal atresia
[ ] Tracheoesophageal fistula
[ ] Other: _____

Musculoskeletal
[ ] Contractures (arthrogryposis)
[ ] Club foot (bilateral)
[ ] Polydactyly
Specify: _____
[ ] Syndactyly
Specify: _____
[ ] Clenched hands

Please include any

As a participant in the ICCG (Inte
information and test results to a
genetic changes and clinical sy
calling the laboratory at 608-262
[ ] Indicate refusal for inclusion

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.

Please call our laboratory at 608-262-0402 with any questions.