Cleveland Clinic
Laboratories

2119 E. 93rd / L15
Cleveland, OH 44106
216.444.5755 or 800.628.6816

CHROMOSOME BREAKAGE (STRESS) TEST REQUISITION FORM

PLEASE PRINT

Patient's Name: _____

Date of Birth: _____ / _____ / _____ Gender: ☐ Female ☐ Male

Patient's Cleveland Clinic No.: _____ WBC: _____

Diagnosis: _____

HOSPITAL BILLING INFORMATION

Hospital Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Hospital Fax No.: (_____) _____

LABORATORY USE ONLY

FA CENTER No.: _____ Date: _____

Check all that appropriate:

☐ Small, short stature

☐ Skin spots (hypo pigmentation and/or café au lait spots

Abnormality: ☐ Skeletal ☐ Thumb

☐ Low blood count

☐ Kidney Ultrasound Abnormality

Referring Physician: _____

Department: _____

Phone No.: (_____) _____

Signature: _____