



This form must be completed fully for array CGH analysis requests and must be accompanied by a standard Genetics "Request for Chromosome & DNA Analysis" form. Failure to do so may result in delay or failure to process the sample.

Surname:	First name(s):	Date of Birth:	Sex: M / F
Consultant:	Hospital:		

Suspected syndrome: Please specify:

Relevant family history:

CLINICAL FEATURES	<i>Please circle / complete where applicable</i>
Developmental delay/ Learning difficulties/Autism	Mild / Moderate / Severe
Cleft Lip	Y / N
Cleft Palate	Y / N
Heart defects	Y / N If "Y", please specify:
Limb Anomaly	Upper / Lower / Hand / Foot Please give details:
Microcephaly	Y / N
Macrocephaly	Y / N
MRI brain anomaly	Y / N If "Y", please specify:
Overgrowth	Y / N
Growth below the third centile	Y / N
Dysmorphic	Y / N If "Y", please specify:
Other anomaly	Y / N If "Y", please specify:
Any previous genetic tests:	Y / N If "Y", please specify: