Wisconsin State Laboratory of Hygiene
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VARIANT REANALYSIS REQUEST

UWCS Use Only:

Lab Number: ________________
Request received by: ____________
(initials and date)

Date: ____

Patient Name: ________________________________

Case (CYG) Number: __________________________

Requested By: ________________________________ Signature: _______________________________

Provider Contact Phone Number: __________________________

Please list additional relevant clinical findings related to the proband or family in the box below:

Fax this form to 608.265.7818 to initiate reanalysis request.
An amended test report will be issued to the original ordering provider within 1-4 weeks of receipt of request.
Please call our laboratory with additional questions 608-262-0402

http://www.slh.wisc.edu/clinical/cytogenetics/