

MICHIGAN BIRTH DEFECTS REGISTRY

"CYTOGENETICS" REPORT

| | | | |
|---|---|---|---|
| 1. NAME OF CHILD | | | |
| (Last) | (First) | (Middle initial) | |
| 2. IF THE CHILD HAS BEEN IDENTIFIED BY ANOTHER NAME (AKA - also known as) | | | |
| 3. CHILD'S CURRENT STREET ADDRESS _____ CITY _____ | | APARTMENT No. _____ STATE _____ | P.O. BOX No. _____ ZIP CODE _____ |
| 4. CHILD'S SOCIAL SECURITY No. (if known) | 6. MEDICAL RECORD No. | 8. SEX <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Undesignated | 10. PLURALITY <input type="checkbox"/> Single <input type="checkbox"/> First <input type="checkbox"/> Second <input type="checkbox"/> Third or More |
| 5. CHILD'S MEDICAID No. (if known) | 7. DATE OF BIRTH (Month) (Day) (Year) _____-_____-_____ | 9. DECEASED <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 11. HOSPITAL - PLACE OF BIRTH _____ | | | |
| 12. MOTHER'S LAST NAME | FIRST NAME | M.I. | SOCIAL SECURITY No. |
| _____ | _____ | _____ | _____ |
| 13. HOSPITAL - PLACE OF DIAGNOSIS | CITY | STATE | |
| 14. <u>CYTOGENETICS</u> - DESCRIBE FINDINGS | ICD - 9 - CM CODE | | |
| _____ | _____ | | |
| _____ | _____ | | |
| _____ | _____ | | |
| 15. NAME OF LABORATORY | CITY | | |
| 16. <u>LAST NAME</u> OF PERSON COMPLETING THIS FORM (LAST) | <u>FIRST NAME</u> OF PERSON COMPLETING THIS FORM (FIRST) | | |
| TELEPHONE NUMBER | DATE COMPLETED | | |
| _____ | (Month) _____ (Day) _____ (Year) _____ | | |

PLEASE RETURN TO:

**Michigan Department of Community Health
 Vital Records & Health Data Development Section
 1001 Terminal Road, Lansing, MI 48906**