

Office Use Only: _____

Microarray Core

Please print, complete and bring with your samples

*LSUHSC Microarray Core and Genome Bioinformatics Center
Gene Therapy program, 533 Bolivar Street, Room 537
New Orleans, LA 70112
Phone: (504) 568-4552 Fax: (504) 568-8500*

Date: _____

Name of Principal Investigator: _____

Name of person requesting service (if different): _____

Lab Phone Number: _____

Email: _____

Billing Account Number: _____

Service (A, B, C)	Sample Name/ Tube I.D.	Prep. Method	Stage (RNA, cRNA, etc.)	Conc. ($\mu\text{g}/\mu\text{L}$)	Array Type (Human, mouse, etc.)

Additional Comments/ Instructions: