



FHCRC GENOMICS RESOURCE
 DNA ARRAY LABORATORY
 1100 FAIRVIEW AVE N, DE-740
 SEATTLE, WA 98109

Date: _____

AMPLIFIED RNA COUPLING REQUEST FORM

Contact Information

Name: _____
 Organization: _____
 E-Mail: _____
 Phone: _____
 PI Name: _____

Billing Information

Billing Contact: _____
 Purchase Order # (External) _____
 Program # (FHCRC) _____

Sample Information

Organism/Chip Type: _____ Amplification Method: _____

Choose One: RNA Type (aa-Modified or Unmodified).

****aRNA submitted for coupling must be at a concentration no less than 0.950 ng/ μ l with 4 μ g required per channel per chip for labeling. NOTE: Oligo arrays require amino-allyl modified aRNA.**

	Sample ID	RNA (μ g/ μ L) **	A ₂₆₀ /A ₂₈₀
Chip 1	Cy3: _____		
	Cy5: _____		
Chip 2	Cy3: _____		
	Cy5: _____		
Chip 3	Cy3: _____		
	Cy5: _____		
Chip 4	Cy3: _____		
	Cy5: _____		
Chip 5	Cy3: _____		
	Cy5: _____		
Chip 6	Cy3: _____		
	Cy5: _____		
Chip 7	Cy3: _____		
	Cy5: _____		
Chip 8	Cy3: _____		
	Cy5: _____		
Chip 9	Cy3: _____		
	Cy5: _____		