Hamilton Health Sciences

Molecular Diagnostic Genetics Requisition

McMaster University Medical Centre
Molecular Genetics Laboratory, Room 2N22
1200 Main Street West, Hamilton, ON L8N 3Z5

Telephone: 905-521-2100 ex.76944
Fax: 905-521-7913
Email: moleculargenetics@hhsc.ca

***Patient Last Name:** ***First Name:**

***DOB (DD/MM/YY)**

***SEX** ❑M ❑F

***Health Card No:** [redacted]

***Mandatory Information**
(Specimen cannot be processed without this data)

Test Requested:

Please see the HRLMP Laboratory Test Information Guide for complete sample requirements and information http://www.ltig.hrlmp.ca

☒ Hemoglobinopathy
Ethnicity:_____
- ❑ Thalassemia
- ❑ Hemoglobin Variant
- ❑ Sickle Cell Disease

***CBC, Hemoglobin electrophoresis, and ferritin results are required for processing samples.**

- ❑ Hemochromatosis (*HFE*)
- ❑ Metachromatic Leukodystrophy (*ARSA*)
- ❑ Smith-Lemli-Opitz Syndrome (*DHCR7*)
- ❑ Medium Chain Acyl-Coenzyme Deficiency (*ACADM*)
- ❑ Very Long Chain Acyl-Coenzyme Deficiency (*ACADVL*)
- ❑ Gamma Polymerase Deficiency (*POLG*)
- ❑ Galactosemia (*GALT*)
- ❑ Glucose-6-Phosphate Dehydrogenase Deficiency(*G6PD*)
- ❑ Pyruvate Kinase Deficiency (*PKLR*)
- ❑ Hyperferritinaemia Cataract Syndrome (*FTL*)
- ❑ Bank DNA until further notice
- ■ Other (Enquire) _____

Specimen Information:

Transport at room temperature to the above address
Date sample taken/location: (DD/MM/YY)_____

- ☒ Peripheral Blood in EDTA – 5ml
- ❑ DNA, minimum 6 micrograms Source:_____
- ❑ Amniotic Fluid, 10-15ml, back-up culture required
- ❑ Cleaned Chorionic Villi, 5-15mg, back-up culture required
- ❑ Cultured cells, confluent, 1xT25 flask, back-up culture required

Clinical Indications:

- ❑ Symptoms of indicated disease
- ❑ Carrier status
- ❑ Newborn Screen Positive
- ❑ Prenatal Diagnosis (provide information below)

  Pregnancy Information

  LMP (DD/MM/YY):_____

  Procedure/Date (DD/MM/YY):_____
- ❑ Family history (Please provide details below)

  ❑ Index Case **OR**

  Index Case Name:_____

  DOB (DD/MM/YY):_____

  Relationship:_____

  PROVIDE A SEPARATE PEDIGREE
- ❑ Other_____

Expedited Cases are limited to: Prenatal Diagnosis, Newborn Screen Positive, or Patient/Partner Pregnant.

Reports To: **Report will not be sent without complete information!**

*Ordering Physician:
*Address:

*Phone:
*Fax:

*Authorized Signature:_____

Additional Copy to: Dynacare Hemoglobinopathy Screening Clinic
Physician:

Address: 115 Midair Court, Brampton ON L6T 5M3

Please send to Fax# 450-901-3076

Lab Use Only: