Molecular Genetics Diagnostics Laboratory Test Requisition

DELIVER TO:

CHEO Molecular Genetics Diagnostic Laboratory
Room W3403
401 chemin Smyth Road
Ottawa, ON Canada K1H 8L1
Phone: (613) 738-3230 Fax: (613) 738-4814

HEALTH CARE PROVIDER(S) REQUESTING TEST:

NAME _____

ADDRESS _____

CITY _____PROV. _____ POSTAL CODE _____

CONTACT: _____

PHONE NO. _____ FAX NO. _____

AUTHORIZED SIGNATURE:

_____

PATIENT NAME
(LAST) (FIRST)

ADDRESS

CITY PROV. POSTAL CODE

DATE OF BIRTH SEX: F M
DD/MM/YYYYY

FACILITY PATIENT ID NUMBER _____

PROVINCIAL HEALTH NUMBER _____

PEDIGREE NUMBER_____

FOR LAB USE ONLY:

COLLECTED BY: _____

PHLEBOTOMIST COLLECTION DATE: _____
(DD/MM/YYY)

LAB NUMBER _____

IF AN ADDITIONAL REPORT IS BEING REQUESTED, PLEASE COMPLETE THE FOLLOWING:

PROVIDER NAME _____

ADDRESS _____CITY _____PROV. _____ POSTAL CODE _____

Test Requested

- ☐ Angelman Syndrome
- ☐ Charcot-Marie Tooth Type 1A
- ☐ Cystic Fibrosis (*ethnic background **must** be specified below*)*****
- ☐ Cystinosis (*ethnic background **must** be specified below*)*****
- ☐ Facioscapulohumeral Muscular Dystrophy
- ☐ Factor V Leiden and Factor II Prothrombin
- ☐ Fetal RhD
- ☐ Fetal Kell
- ☐ Fetal Platelet Antigen (PLA1)
- ☐ Fragile X Syndrome
- ☐ Hereditary Neuropathy with Liability to Pressure Palsies
- ☐ Hereditary Non-Syndromic Deafness (*ethnic background **must** be specified below*)*****
- ☐ HFE-related hemochromatosis
- ☐ Maternal Cell Contamination Studies
- ☐ Myotonic Dystrophy Type 1 (*ethnic background **must** be specified below*)*****
- ☐ Myotonic Dystrophy Type II
- ☐ Oculopharyngeal Muscular Dystrophy
- ☐ Pompe Disease
- ☐ Prader-Willi Syndrome
- ☐ Rett Syndrome
- ☐ Spinal Muscular Atrophy
- ☐ Ocular Stickler Syndrome
- ☐ X-Inactivation
- ☐ Zygosity Testing
- ☐ Fetal Sexing

☐ **Bank DNA until further notice**

*** Ethnic Background** (e.g. Ashkenazi Jewish, Asian, French Canadian, Northern European)

Sample Required

- ☐ Blood 10 mL EDTA
- ☐ Blood 3 mL EDTA (infant only)
- ☐ DNA ___ ug
- ☐ Other _____
- ☐ Cultured Amniocytes
- ☐ Amniotic Fluid 5 mL
- ☐ Cultured CVS
- ☐ CVS

Sample Information

- ☐ **Routine**
- ☐ **Expedited**
  - ☐ Patient/Partner Pregnant
  - ☐ Prenatal Diagnosis
  - ☐ Newborn (less than 3 months of age)

Reason for Test

- ☐ Symptoms of Indicated Disease
- ☐ Carrier Status
- ☐ Predictive Testing
- ☐ Prenatal Diagnosis *(parental bloods are required)*
- ☐ Other: _____

Other family member(s) tested previously:

☐ No
☐ Yes – name: _____
relationship to patient: _____
Attach copy of result (if available)

Additional relevant clinical and/or family history information: