Pathology and Molecular Medicine
KINGSTON GENERAL HOSPITAL
CLINICAL LABORATORY SERVICES

KINGSTON GENERAL HOSPITAL, Molecular Genetics Laboratory
76 Stuart Street, Douglas 4, Room 8-415, Kingston, ON K7L 2V7
(613) 549-6666 ext. 4892 FAX: (613) 548-1356
In-house delivery tube station: 31
http://www.path.queensu.ca/DNA_Diagnostics_-95851.html

Contact Person & Number:

Ordering Physician: (Full name, institution, phone & fax):

Other Physician (Full name, address)

Ordering Physician's Signature: _____

CR# or Hosp. ID #: _____

Name _____ (M/F)
(Surname) (First Name)

Address _____

Health # _____ **DOB** ____/____/____
Expiry Date: _____ YYYY MM DD

Date of Collection: ____/____/____ **Time:** _____
YYYY MM DD

Collected by: _____ (Signature)

Hospital Location: _____

Ordering Physician's Name (Please Print): _____

Test Requested

- ☐ Adrenoleukodystrophy
- ☐ Familial Thrombosis(Factor V Leiden, Prothrombin variant)
- ☐ Fragile X Syndrome
- ☐ Hemochromatosis
- ☐ Hemophilia A
- ☐ Hemophilia B
- ☐ Huntington's Disease
- ☐ X-linked Hydrocephalus
- ☐ Other:_____

Information Requested

- ☐ Confirm clinical diagnosis
- ☐ Carrier Status
- ☐ Predictive testing
- ☐ Prenatal Diagnosis
- ☐ Determine feasibility of prenatal Dx
- ☐ Family study (no report for this individual)
- ☐ None: for research only
- ☐ Bank DNA until further notice
- ☐ Other: _____

Reason for Referral

- ☐ Documented family history of indicated disease
- ☐ Possible family history of indicated disease
  if either one is checked please complete Family Information Section
- ☐ Symptoms of indicated disease in this individual
- ☐ Other:

PROVIDE DETAILS ON PEDIGREE

*Family Information

Have samples from this family been sent to a DNA lab before? ☐yes ☐no
If Yes, specify _____

Individual born in _____ (place) Ethnic background _____

- ☐ This individual is the index case OR:
- ☐ Name of Index Case in the Family _____ DOB: ____/____/____ YYYY MM DD

Relationship to this patient: _____

Pregnancy Information

If this individual or the partner of this individual is currently pregnant:

L.M.P. (YYYY/MM/DD) ____/____/____

Amnio (YYYY/MM/DD) ____/____/____

CVS (YYYY/MM/DD) ____/____/____

Sample Requirements (minimal requirements all at room temperature – delivered within 24 hours)

Blood
- ☐ EDTA (lavender or pink -top) 10 cc
  or
- ☐ ACD (yellow-top) 10 cc

Prenatal
- ☐ amniotic fluid 3-10 cc
- ☐ cultured amniocytes 2 x T25 Flask(s)
- ☐ CVS sample - please call lab (549-6666 x4892)

Other
- ☐ DNA _____ ug ☐ Other (specify)_____

A PEDIGREE MUST BE PROVIDED IN CASES WHERE LINKAGE ANALYSIS IS REQUESTED AND IF THERE IS A FAMILY HISTORY OF INDICATED DISEASE. (Identify Each Individual)

In some instances the laboratory may be unable to meet the turn around times indicated in the KGH Laboratory's User's Handbook, if results are required for clinical management please notify the laboratory as soon as possible.
http://kgh/clinical_laboratory_services/LabUserManual.pdf