

Dynacare Genetic Testing Requisition

Note: This requisition must accompany the sample

Prescriber Information

Last Name: _____

First Name: _____

Clinic: _____

Address: _____

No. Street Office

City. Prov. Postal Code

Tel: _____

Fax: _____

Fax CC: _____

Licence No.: _____

Genetic Counsellor:

Name: _____

Tel: _____

Email: _____

Signature: _____

Date (YYYYMMDD)

Clinician Acknowledgment of Informed Consent

The patient has provided me with their permission to permit Dynacare or its affiliated laboratory (located in the United States) to provide the laboratory test(s) indicated herein. They understand that their personal health information (including name, date of birth and gender) will accompany the specimen and that this information may be subject to disclosure to government or other authorities. The patient has had the opportunity to ask questions and discuss the capabilities, limitations and possible risks of the test(s) with me, their healthcare provider.

Other relevant clinical information that justifies testing: (Please include all symptoms that justify testing: _____)

Ethnicity (check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> African/African American | <input type="checkbox"/> Other/Mixed Caucasian |
| <input type="checkbox"/> Caucasian | <input type="checkbox"/> Native American |
| <input type="checkbox"/> French Canadian or Acadian | <input type="checkbox"/> Hispanic |
| <input type="checkbox"/> Middle Eastern | <input type="checkbox"/> Southern European
<i>e.g. Italian, Greek</i> |
| <input type="checkbox"/> Northern European
<i>e.g. British, German</i> | <input type="checkbox"/> Southeast Asian |
| <input type="checkbox"/> South Asian <i>e.g. Indian, Pakistani</i> | <input type="checkbox"/> Southeast Asian
<i>e.g. Filipino, Vietnamese</i> |
| <input type="checkbox"/> East Asian <i>e.g. Chinese, Japanese</i> | <input type="checkbox"/> Pacific Islander |
| <input type="checkbox"/> Ashkenazi Jewish | <input type="checkbox"/> Other _____ |

Patient Information

Last Name: _____

First Name: _____

Date of Birth: _____

Date (YYYYMMDD)

Sex at birth: Female Male

Health Insurance No: _____

(RAMQ, OHIP, etc.)

MRN: _____

Address: _____

No. Street Office

City. Prov. Postal Code

Tel (primary): _____

Tel (secondary): _____

Is this patient currently pregnant?

Yes Dating: _____ wks No

LMP

Ultrasound

Is the patient deceased?

Yes No

Has the patient received a transfusion of blood or granulocytes in the past month?

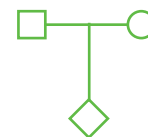
Yes No

Has the patient undergone transplantation?

Yes No

If yes, please specify: Date (Year/Month/Day): _____

Family History (or attach pedigree if available)



Patient Name: _____

Date of Birth (yyyy/mm/dd): _____

Patient Consent

My signature on this form indicates that I give permission to Dynacare or affiliated laboratory to provide the laboratory test(s) indicated. I have had the opportunity to ask questions and discuss the capabilities, limitations, and possible risks of the test(s) with my healthcare provider or someone my healthcare provider has designated. I know that if I wish, I may obtain professional genetic counselling before signing this consent. I understand that my specimen will be sent to a laboratory in the United States for testing. I understand that personal information, including but not limited to my name and date of birth, will accompany the sample. Personal information held in countries outside of Canada could be subject to disclosure to government or other authorities (whether of that country or of another country). Note: For whole exome and whole genome sequencing, please read and sign the Informed Consent for Whole Exome & Whole Genome Sequencing at the end of this document.

Signature: _____

Date: _____

Date (YYYYMMDD)

Indication for Testing

Indication for testing: Diagnosis Family history Known Familial mutation/pathogenic variant (Include mutation variant report) Other:

Requested Tests

Test Code: _____ Test Name: _____

Test Code: _____ Test Name: _____

Test Code: _____ Test Name: _____

STAT Request Yes* No *Additional fees will apply for STAT requests

*If RNA testing is required please phone Dynacare at 888.988.1888 for further instructions

Sample Type

Collection Date & time: _____
(YYYY/MM/DD)

Collection Location: * To request home collection call 1-888-988-1888.

Whole Blood:

- Adult: 2 x 4 mL EDTA (lavender-top tube)
- Adult: 2x4 ml Sodium Heparin (Green-top tube)
- Pediatric: 1 x 2 mL EDTA

Whole Blood RNA: (Contact Dynacare to order MNG RNA collection kit)

- Plasma/ Serum
- Bone Marrow (Min 2ml EDTA at room temperature)
- DNA: 15-100 Qg (50 ug/mL)

Amount: _____ ug/mL

Concentration: _____ ug/mL

- Buccal Swab
- Saliva
- Filter card

Prenatal samples

- Direct CVS: Min. 10 mg direct villi
- Direct Amniocentesis: As much volume as possible in conical tube at room temperature (received within 48 hours)

- Cultured Villi: 1-2 confluent T25 flasks
- Cultured Amniocytes: 1-2 confluent T25 flasks

- Cord Blood: 1-2 ml EDTA (* also provide maternal blood for MCC - 2ml EDTA)

Tissue:

- Muscle
- Fibroblasts (skin biopsy):
- Other: _____
- Cultured Cells: 2 T25 flasks, 80-90% confluent
- Snap Frozen (provide tissue type)
- FFPE Slides: Surgical # _____
- FFPE Blocks: Surgical # _____

CSF: Ship CSF samples directly to MNG Labs at: 5424 Glenridge Drive, NE, Atlanta, Georgia 30342 USA and fax requisition to 450.901.3075

- Urine
- Tumor to follow
- Other

Tumor type:

- Tumor Type
- Lung Breast Colon Melanoma Kidney
 - Other: _____

Stage:

Stage _____

Payment Information

(Please complete payment form as well)

- Ministry of Health Private Insurance
- Institutional Patient/ Private Pay

Patient Name:

Date of Birth (yyyy/mm/dd):

Family Member 1 Information (Must Include for Exome Trio)

Last Name: _____

First Name: _____

Date of Birth: _____

Relationship to Proband: _____

(YYYY/MM/DD)

Collection Date: _____

Sex at birth: Female Male

Affected? Yes No Unsure (Include Clinical Info)

Clinical Info

Specimen Type:

Whole Blood Buccal Swab

DNA Tissue: _____

Other: _____

Family Member 2 Information (Must Include for Exome Trio)

Last Name: _____

First Name: _____

Date of Birth: _____

Relationship to Proband: _____

(YYYY/MM/DD)

Collection Date: _____

Sex at birth: Female Male

Affected? Yes No Unsure (Include Clinical Info)

Clinical Info

Specimen Type:

Whole Blood Buccal Swab

DNA Tissue: _____

Other: _____