Dynacare®

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)

- ☐ African/African American
- ☐ Caucasian
- ☐ French Canadian or Acadian
- ☐ Middle Eastern
- ☐ Northern European *e.g. British, German*
- ☐ South Asian *e.g. Indian, Pakistani*
- ☐ East Asian *e.g. Chinese, Japanese*
- ☐ Ashkenazi Jewish
- ☐ Other/Mixed Caucasian
- ☐ Native American
- ☐ Hispanic
- ☐ Southern European *e.g. Italian, Greek*
- ☐ Southeast Asian *e.g. Filipino, Vietnamese*
- ☐ Pacific Islander
- ☐ 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): _____

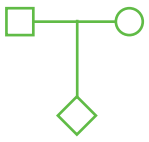
Is this patient currently pregnant?
☐ Yes Dating: _____wks ☐ No
☐ LMP
☐ Ultrasound

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 avaiable)



Patient Name:

Date of Birth (yyyy/mm/dd):

DYNACARE GENETIC TESTING REQUISITION

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

(YYYY/MM/DD)

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

Dynacare®

Patient Name:

Date of Birth (yyyy/mm/dd):

Family Member 1 Information (Must Include for Exome Trio)

Last Name: _____

First Name: _____

Date of Birth: _____
(YYYY/MM/DD)

Relationship to Proband: _____

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: _____
(YYYY/MM/DD)

Relationship to Proband: _____

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: _____