

# Dynacare RNA Sequencing Test Requisition

**\*\*PLEASE CONTACT DYNACARE AT 1-888-988-1888/ DynacareGenetics@dynacare.ca PRIOR TO ORDERING THIS TESTING TO ENSURE CORRECT SAMPLE TYPE IS COLLECTED\*\*** 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"/> Native American                                     |
| <input type="checkbox"/> Caucasian                                     | <input type="checkbox"/> Hispanic  |
| <input type="checkbox"/> French Canadian or Acadian                    | <input type="checkbox"/> Southern European<br><i>e.g. Italian, Greek</i>     |
| <input type="checkbox"/> Middle Eastern                                | <input type="checkbox"/> Southeast Asian<br><i>e.g. Filipino, Vietnamese</i> |
| <input type="checkbox"/> Northern European <i>e.g. British, German</i> | <input type="checkbox"/> Pacific Islander                                    |
| <input type="checkbox"/> South Asian <i>e.g. Indian, Pakistani</i>     | <input type="checkbox"/> Other _____   |
| <input type="checkbox"/> East Asian <i>e.g. Chinese, Japanese</i>      |  |
| <input type="checkbox"/> Ashkenazi Jewish                              |  |
| <input type="checkbox"/> Other/Mixed Caucasian                         |  |

## Patient Information

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex at birth:

Date (YYYYMMDD)

Female  Male

Health Insurance No: \_\_\_\_\_

(RAMQ, OHIP, etc.)

MRN: \_\_\_\_\_

Address: \_\_\_\_\_

No. Street Office

City. Prov. Postal Code

Tel (primary): \_\_\_\_\_

Tel (secondary): \_\_\_\_\_

Patient previously tested at MNG?  Yes  No

If 'YES' please provide the following:

\_\_\_\_/\_\_\_\_/\_\_\_\_ MNG Report Date [MM/DD/YYYY]

MNG ID/ Accession ID # \_\_\_\_\_

Dynacare ID# \_\_\_\_\_

Is this patient currently pregnant?

Yes Dating: \_\_\_\_\_ wks  No

LMP

Ultrasound

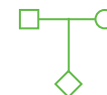
Is the patient deceased?  Yes  No

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: \_\_\_\_\_

(YYYYMMDD)

## Indication For Testing

- Indication for testing:
- Variant of Unknown Significance (VUS) in Regulatory Region
  - Intragenic Deletions/ Duplications
  - Variant of Unknown Significance (VUS) in 3' or 5' Untranslated Regions (UTR)
  - Variants affecting splicing
  - Large Genomic Deletions/ Duplications
  - Abnormal Cytogenetic Studies

**\*\*PLEASE INCLUDE REPORTS FOR RELEVANT, PREVIOUSLY PERFORMED MOLECULAR & CYTOGENETIC TESTING\*\***

## RNA Sequencing

**\*Prior to order RNA testing please phone Dynacare at 888.988.1888 further instructions and to avoid delays in sample processing. Cancer genes cannot be analyzed at the current time for RNA studies**

- Test Code# RNA001 Comprehensive Transcriptome: Full RNA sequencing. Please include any previous genomic data or a copy of the report
- 
- Test Code# RNA002 Panel Specific RNA Sequencing: One Panel NGS Panel Test Code# \_\_\_\_\_
- 
- Test Code# RNA003 Gene Specific RNA Sequencing (1-5 genes): Up to 5 Genes 1)\_\_\_\_\_ 2)\_\_\_\_\_ 3)\_\_\_\_\_ 4)\_\_\_\_\_ 5)\_\_\_\_\_

## Sample Type

**\*\*PLEASE CONTACT DYNACARE TO ENSURE CORRECT SAMPLE TYPE IS COLLECTED - NOT EVERY GENE IS EXPRESSED IN EVERY TISSUE\*\***Collection Date & time: \_\_\_\_\_ Collection Location: \* To request home collection call 1-888-988-1888.  
(YYYY/MM/DD)

- Whole Blood RNA (Contact Dynacare to order MNG RNA collection kit)
- Fibroblasts  Cultured Cells 2 T25 flasks, 80-90% confluent  Muscle Biopsy

## Payment Information (Please complete payment form as well)

- No Charge - reflex from previous MNG Exome or Genome  Patient/ Private Pay
- Institutional  Private Insurance
- Ministry of Health

### Patient Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Date (YYYYMMDD)

### Clinical Information

**(CHECK ALL THAT APPLY - ONLY NEEDED IF NOT SENT WITH PREVIOUS DNA TESTING, IF THERE HAS BEEN CHANGES OR IF gDNA TESTING DONE AT ANOTHER LABORATORY)**

<b>Eye:</b> <input type="checkbox"/> Retinitis Pigmentosa <input type="checkbox"/> Optic Atrophy <input type="checkbox"/> Other	<b>Hearing</b> <input type="checkbox"/> Sensorineural <input type="checkbox"/> Stickler <input type="checkbox"/> Usher	<b>Neuronal Migration</b> <input type="checkbox"/> Meckel <input type="checkbox"/> Joubert <input type="checkbox"/> Other	<input type="checkbox"/> Stroke
<b>Cognitive/Neurobehavioral</b> <input type="checkbox"/> Intellectual Disability (ID) <input type="checkbox"/> Syndromic ID <input type="checkbox"/> Nonsyndromic ID <input type="checkbox"/> Autism <input type="checkbox"/> Dementia	<b>Movement Disorders</b> <input type="checkbox"/> Ataxia <input type="checkbox"/> Episodic Ataxia <input type="checkbox"/> Dystonia <input type="checkbox"/> Chorea/Athetosis <input type="checkbox"/> Parkinson Disease <input type="checkbox"/> L-Dopa Response	<b>Epilepsy</b> <input type="checkbox"/> Myoclonic <input type="checkbox"/> Absence <input type="checkbox"/> Tonic Clonic <input type="checkbox"/> Epileptic Encephalopathy <input type="checkbox"/> Other	<b>Spasticity</b> <input type="checkbox"/> Spastic Paraplegia <input type="checkbox"/> Spastic Quadriplegia <input type="checkbox"/> Other
<b>Cardiomyopathy</b> <input type="checkbox"/> Dilated <input type="checkbox"/> Noncompaction <input type="checkbox"/> Hypertrophic	<b>Arrhythmias</b> <input type="checkbox"/> Ventricular Tachycardia <input type="checkbox"/> Brugada <input type="checkbox"/> Long or Short QT <input type="checkbox"/> Conduction Defect	<b>Congenital Heart Defects</b> <input type="checkbox"/> Heterotaxy <input type="checkbox"/> Other	<b>Endocrine</b> <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Diabetes Mellitus <input type="checkbox"/> Other
<b>Connective Tissue &amp; Bone</b> <input type="checkbox"/> Ehlers Danlos <input type="checkbox"/> Marfan <input type="checkbox"/> Aneurysms <input type="checkbox"/> Other	<b>Neuromuscular</b> <input type="checkbox"/> Distal <input type="checkbox"/> Proximal <input type="checkbox"/> Malignant Hyperthermia <input type="checkbox"/> Periodic Paralysis <input type="checkbox"/> Muscle Atrophy	<input type="checkbox"/> Arthrogyrosis <input type="checkbox"/> Statin Use <input type="checkbox"/> Contractures <input type="checkbox"/> Rhabdomyolysis <input type="checkbox"/> Myasthenia	<b>Nerve/Anterior Horn Cell</b> <input type="checkbox"/> Neurofibromas <input type="checkbox"/> Charcot-Marie-Tooth <input type="checkbox"/> Sensory <input type="checkbox"/> Autonomic <input type="checkbox"/> Pain <input type="checkbox"/> Motor <input type="checkbox"/> Nerve Conduction <input type="checkbox"/> Other

### Imaging (CHECK ALL THAT APPLY)

#### Brain MRI

- |  |   |
|--|---|
| <input type="checkbox"/> Leigh Disease               | <input type="checkbox"/> Cerebellar Atrophy         |
| <input type="checkbox"/> Basal Ganglia Calcification | <input type="checkbox"/> Abnormal Myelin (describe) |
| <input type="checkbox"/> Stroke                      |   |

#### EMG/NVC (Describe Findings):

#### EEG (Describe Findings):

### Laboratory

#### Genetic (Describe Findings):

- Chromosomal Microarray  
 Deletion/Insertion Testing  
 Other:

#### Metabolic (Describe Findings)

CPK: Maximum \_\_\_\_\_ Minimum \_\_\_\_\_

Additional Comments