Dynacare®

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)

- ☐ 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: _____ Sex at birth: ☐ Female ☐ Male
Date (YYYYMMDD)

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# _____

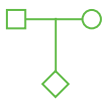
Is this patient currently pregnant?
☐ Yes Dating: _____wks ☐ No
☐ LMP
☐ Ultrasound

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):

DYNACARE RNA SEQUENCING TEST 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: _____
(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

DYNACARE RNA SEQUENCING TEST REQUISITION

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)

Eye:
- ☐ Retinitis Pigmentosa
- ☐ Optic Atrophy
- ☐ Other

Hearing
- ☐ Sensorineural
- ☐ Stickler
- ☐ Usher

Neuronal Migration
- ☐ Meckel
- ☐ Joubert
- ☐ Other

- ☐ Stroke

Cognitive/Neurobehavioral
- ☐ Intellectual Disability (ID)
- ☐ Syndromic ID
- ☐ Nonsyndromic ID
- ☐ Autism
- ☐ Dementia

Movement Disorders
- ☐ Ataxia
- ☐ Episodic Ataxia
- ☐ Dystonia
- ☐ Chorea/Athetosis
- ☐ Parkinson Disease
- ☐ L-Dopa Response

Epilepsy
- ☐ Myoclonic
- ☐ Absence
- ☐ Tonic Clonic
- ☐ Epileptic Encephalopathy
- ☐ Other

Spasticity
- ☐ Spastic Paraplegia
- ☐ Spastic Quadriplegia
- ☐ Other

Cardiomyopathy
- ☐ Dilated
- ☐ Noncompaction
- ☐ Hypertrophic

Arrhythmias
- ☐ Ventricular Tachycardia
- ☐ Brugada
- ☐ Long or Short QT
- ☐ Conduction Defect

Congenital Heart Defects
- ☐ Heterotaxy
- ☐ Other

Endocrine
- ☐ Hypothyroidism
- ☐ Diabetes Mellitus
- ☐ Other

Connective Tissue & Bone
- ☐ Ehlers Danlos
- ☐ Marfan
- ☐ Aneurysms
- ☐ Other

Neuromuscular
- ☐ Distal
- ☐ Proxima
- ☐ Malignant Hyperthermia
- ☐ Periodic Paralysis
- ☐ Muscle Atrophy

- ☐ Arthrogryposis
- ☐ Statin Use
- ☐ Contractures
- ☐ Rhabdomyolysis
- ☐ Myasthenia

Nerve/Anterior Horn Cell
- ☐ Neurofibromas
- ☐ Charcot-Marie-Tooth
- ☐ Sensory
- ☐ Autonomic
- ☐ Pain
- ☐ Motor
- ☐ Nerve Conduction
- ☐ Other

Imaging **(CHECK ALL THAT APPLY)**

Brain MRI
- ☐ Leigh Disease
- ☐ Basal Ganglia Calcification
- ☐ Stroke
- ☐ Cerebellar Atrophy
- ☐ Abnormal Myelin (describe)

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