Cytogenetics Requisition
Genetics Diagnostic Laboratory
401 Smyth Road, Rm w3401
Ottawa, ON, K1H 8L1
Tel: (613) 738-3230 Fax: (613) 738-4814

STAMP

Patient Name: _____
Last First Initial
Health Card Number: _____
DOB: (yy/mm/dd) _____
Address: _____
_____
Telephone: _____
Sex (circle one): ◯ Male ◯ Female

PRINT

ALL SECTIONS MUST BE COMPLETED

Collection Date: _____ Time: _____

Collection Centre:
☐ CHEO Inpatient ☐ CHEO Outpatient
☐ Other location (specify): _____
Specimen collected by: _____

Health Care Provider Requesting Test

Name: _____
Registration Number: _____
Address: _____
_____
Telephone: _____
FAX: _____

Copy to: Name: _____
Registration Number: _____
Address: _____
_____
Telephone: _____
FAX: _____

Test Requested

Refer to website for testing services available at: https://www.cheo.on.ca/en/clinics-services-programs/genetics-diagnostic-laboratory.aspx

☐ Standard Chromosome Analysis/ Karyotype
☐ Follow-up testing based on Microarray findings: ◯ FISH Custom Probe ◯ Proband ◯ Family member, relationship to proband: _____
☐ FISH (specify probe(s); refer to website for FISH tests available): _____
☐ RAD (Rapid Aneuploidy Detection)
☐ Tissue Culture: ◯ Hold in culture ◯ Freeze ◯ Other, specify: _____
☐ Shipment: ◯ Direct specimen, to: _____
◯ Cultured cells, to: _____
◯ Cultured cells to the Molecular Genetics section of the Genetics Diagnostic Laboratory
(please attach shipping information and appropriate documentation)

Specimen Type

Collect blood specimens in a sodium heparin tube (10 mL for adults and children, 3 mL for newborns). Do not freeze or spin.
Collection instructions for other specimens available at: https://www.cheo.on.ca/en/clinics-services-programs/sample-requirements-and-shipping.aspx

☐ Amniotic Fluid - **Gestational Age:** _____

☐ Twin/Multiple Pregnancy: ◯ Twin A ◯ Twin B

☐ Chorionic Villus Sample - **Gestational Age :** _____

☐ Blood
☐ Bone Marrow
☐ Solid Tissue source : _____
☐ Fibroblasts source : _____
☐ Tumour source : _____
☐ Other source : _____

Oncology Testing

☐ New Diagnosis ☐ Follow-up ☐ Post Bone Marrow Transplant, *please specify sex of donor*: ◯ Male / ◯ Female
☐ Relapse Treatment: ◯ Yes / ◯ No

If peripheral blood please provide: WBC_____ % Blasts_____

Clinical Indication & Comments

Analysis cannot be performed unless appropriate clinical and/or family history is provided.

Please provide partner's name (if applicable): _____

LABORATORY USE ONLY

Sample size: _____mL or mg
Fluid Quality: ☐ Clear ☐ Cloudy ☐ Slight Blood ☐ Gross Blood ☐ Discoloured
Pellet Quality: ☐ Normal ☐ Tissue ☐ Bloody
Pellet Size: ☐ S ☐ M ☐ L
Villi: ☐ Typical ☐ Atypical ☐ Absent

Lab#_____

Ped#_____

Form No. 2236, May 2022