Genetics Diagnostic Laboratory
Molecular Genetics Test Requisition

DELIVER TO:
CHEO Genetics Diagnostic Laboratory
Room w3401
401 Smyth Road Ottawa, ON
Canada K1H 8L1
Phone: (613) 738-3230 Fax: (613) 738-4814
https://www.cheo.on.ca/en/clinics-services-programs/genetics-diagnostic-laboratory.aspx

HEALTH CARE PROVIDER(S) REQUESTING TEST

NAME: _____
REGISTRATION NUMBER: _____
ADDRESS: _____
CITY: _____ PROV: _____ POSTAL CODE: _____
CONTACT: _____
PHONE NO: _____ FAX NO: _____

IF AN ADDITIONAL REPORT IS REQUIRED, PLEASE COMPLETE THE FOLLOWING:

NAME: _____
REGISTRATION NUMBER: _____
ADDRESS: _____
CITY: _____ PROV: _____ POSTAL CODE: _____
CONTACT: _____
PHONE NO: _____ FAX NO: _____

PATIENT NAME:

_____
(LAST) (FIRST)

ADDRESS: _____
CITY: _____ PROV: _____ POSTAL CODE: _____
DATE OF BIRTH _____ SEX: ☐ M ☐ F
DD/MM/YYYY

FACILITY PATIENT ID NUMBER: _____
PROVINCIAL HEALTH NUMBER: _____

FOR LAB USE ONLY:

COLLECTION DATE: _____
COLLECTION CENTRE: _____
COLLECTED BY: _____

- ☐ Blood 2x 6 mL EDTA
- ☐ Blood 2x 3 mL EDTA (child)
- ☐ Blood 3 mL EDTA (infant ≤1 yr)
- ☐ DNA __ µg (test dependent – see website)
- ☐ Cord blood (provide maternal blood for MCC)*
- ☐ Amniotic Fluid (20 mL)*
- ☐ CVS (10-20 mg)*
- ☐ Cultured Amniocytes (provide two confluent T25 flasks)*
- ☐ Cultured CVS*
- ☐ Other: _____

*Maternal sample (with separate requisition for MCC) is also required for cord blood and prenatal samples.

Priority of testing:

Expedited:
- ☐ Prenatal Diagnosis
- ☐ Patient/Partner Pregnant
- ☐ Newborn (≤ 3 months)

☐ **Routine**

Additional relevant clinical and/or family information:

Other family member(s) tested previously? ☐ No ☐ Yes

Name: _____

CHEO Pedigree number: _____ Relationship: _____

Test requested and reason for testing (check all that apply)

Angelman Syndrome:
- ☐ Symptoms indicative of Angelman Syndrome
- ☐ Carrier testing
- ☐ Predictive testing
- ☐ Prenatal diagnosis (maternal sample, with separate requisition for MCC, also required)

Facioscapulohumeral Muscular Dystrophy (FSHD): *(20 mL EDTA)*
- ☐ Symptoms indicative of FSHD
- ☐ Carrier testing
- ☐ Predictive testing

Thrombophilia (Factor V Leiden and Factor II Prothrombin):
- ☐ Symptoms indicative of Thrombophilia
- ☐ Carrier testing
- ☐ Predictive testing

FMR1-related disease (Fragile X, POF, FXTAS):
- ☐ Symptoms indicative of FMR1-related disease
- ☐ Carrier testing
- ☐ Predictive testing
- ☐ Prenatal diagnosis (maternal sample, with separate requisition for MCC, also required)

HFE-related Hemochromatosis:
- ☐ Symptoms indicative of Hemochromatosis
- ☐ Carrier testing
- ☐ Predictive testing

Myotonic Dystrophy (MD) Type I: *Specify ethnic background: e.g. Ashkenazi Jewish, Asian, French Canadian, Northern European):* _____
- ☐ Symptoms indicative of MD Type I
- ☐ Carrier testing
- ☐ Predictive testing
- ☐ Prenatal diagnosis (maternal sample, with separate requisition for MCC, also required)

Myotonic Dystrophy (MD) Type II:
- ☐ Symptoms indicative of MD Type II
- ☐ Carrier testing
- ☐ Predictive testing

Oculopharyngeal Muscular Dystrophy (OPMD):
- ☐ Symptoms indicative of OPMD
- ☐ Carrier testing
- ☐ Predictive testing

Prader-Willi Syndrome (PWS):
- ☐ Symptoms indicative of PWS
- ☐ Carrier testing
- ☐ Predictive testing
- ☐ Prenatal diagnosis (maternal sample, with separate requisition for MCC, also required)

Spinal Muscular Atrophy (SMA):
- ☐ Symptoms indicative of SMA
- ☐ Carrier testing
- ☐ Predictive testing
- ☐ Prenatal diagnosis (maternal sample, with separate requisition for MCC, also required)

☐ **Maternal Cell Contamination Studies**
☐ **DNA Storage** (DNA will be stored for 2 years and then discarded)