Genetics Diagnostic Laboratory
Molecular Genetics Test Requisition

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 COLLECTION LAB USE ONLY:

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

- ☐ *Blood 2 x 6 mL EDTA
- ☐ *Blood 2 x 3 mL EDTA (child)
- ☐ Blood 3 mL EDTA (infant ≤1 yr)
- ☐ DNA ___ µg
- ☐ Cord blood 3 mL EDTA

For FSHD, collect and ship on the same day at 4℃

- ☐ Direct amniotic fluid 20 mL
- ☐ Direct CVS 10-20 mg
- ☐ Cultured Amniocytes 2 x T25 flasks (confluent)
- ☐ Cultured CVS (2 x T25 flasks (confluent)
- ☐ Other: _____

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 (AS):
- ☐ Symptoms of Indicated Disease
- ☐ Carrier Testing
- ☐ Prenatal Diagnosis (maternal sample, with separate requisition for MCC, also required)

Facioscapulohumeral Muscular Dystrophy (FSHD): (For guidance on sample collection and shipment visit our website)
- ☐ Symptoms of Indicated Disease
- ☐ Predictive Testing

Thrombophilia (Factor V Leiden and Factor II Prothrombin):
- ☐ Symptoms of Indicated Disease
- ☐ Predictive Testing

HFE-related Hemochromatosis (HFE):
- ☐ Symptoms of Indicated Disease
- ☐ Predictive Testing

FMR1-related Disorders (select one):
- ☐ Fragile X Syndrome
- ☐ POI
- ☐ FXTAS

- ☐ Symptoms of Indicated Disease
- ☐ Carrier Testing
- ☐ Predictive Testing
- ☐ Prenatal Diagnosis (maternal sample, with separate requisition for MCC, also required)

Myotonic Dystrophy Type I (DM1):
- ☐ Symptoms of Indicated Disease
- ☐ Predictive Testing
- ☐ Prenatal Diagnosis (maternal sample, with separate requisition for MCC, also required)

Myotonic Dystrophy Type II (DM2):
- ☐ Symptoms of Indicated Disease
- ☐ Predictive Testing

Oculopharyngeal Muscular Dystrophy (OPMD):
- ☐ Symptoms of Indicated Disease
- ☐ Predictive Testing

Prader-Willi Syndrome (PWS):
- ☐ Symptoms of Indicated Disease
- ☐ Carrier Testing
- ☐ Prenatal Diagnosis (maternal sample, with separate requisition for MCC, also required)

Spinal Muscular Atrophy (SMA):
- ☐ Symptoms of Indicated Disease
- ☐ Carrier Testing (provide family history and ethnicity, include CHEO Ped# if applicable):
  _____
  _____
- ☐ Prenatal Diagnosis (maternal sample, with separate requisition for MCC, also required)
- ☐ Newborn Screening Positive (provide SMN2 copy number)
  _____

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