

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: www.cheo.on.ca/en/genetics

- Standard Chromosome Analysis/ Karyotype
- Microarray Follow-Up: FISH Custom Probe Proband Family member, relationship to proband: _____
- FISH: specify probe(s) (see 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: www.cheo.on.ca/en/genetics

- 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.

STAMP
<input type="checkbox"/> Patient Name: _____ <div style="display: flex; justify-content: space-between; width: 80%; margin-left: 20px;"> Last First Initial </div> Health Card Number: _____ DOB: (yy/mm/dd) _____ Address: _____ Telephone: _____ Gender (circle one): Male Female
PRINT

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# _____
