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
www.cheo.on.ca/en/genetics

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/YYYYY

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)*
- ☐ Other _____
- ☐ Amniotic Fluid *(20 mL)*
- ☐ CVS *(10-20 mg)*
- ☐ Cultured Amniocytes*
- ☐ Cultured CVS*

**provide two confluent T25 flasks*

Priority of testing:

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

Reason for testing:

- ☐ Symptoms of Indicated Disease
- ☐ Carrier Testing
- ☐ Predictive Testing
- ☐ Prenatal Diagnosis *(parental samples required)*
- ☐ Other: _____

Test requested:

- ☐ Angelman Syndrome
- ☐ Facioscapulohumeral Muscular Dystrophy *(20 mL EDTA)*
- ☐ Factor V Leiden and Factor II Prothrombin
- ☐ FMR1-related diseases:
  - ☐ Fragile X
  - ☐ POF
  - ☐ FXTAS
- ☐ HFE-related Hemochromatosis
- ☐ Maternal Cell Contamination Studies
- ☐ Myotonic Dystrophy Type I *(specify ethnic background)* **
- ☐ Myotonic Dystrophy Type II
- ☐ Oculopharyngeal Muscular Dystrophy
- ☐ Prader-Willi Syndrome
- ☐ Spinal Muscular Atrophy

☐ DNA Storage *(DNA will be stored for 2 years and then discarded; contact the laboratory directly for longer storage)*

Additional relevant clinical and/or family information:

Other family member(s) tested previously?

- ☐ No
- ☐ Yes Name: _____

CHEO Pedigree number: _____ Relationship: _____

** *(e.g. Ashkenazi Jewish, Asian, French Canadian, Northern European):* _____