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. _____

AUTHORIZED SIGNATURE:

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:

COLLECTED DATE: _____

COLLECTION CENTRE: _____

SPECIMEN COLLECTED BY: _____

IF AN ADDITIONAL REPORT IS BEING REQUESTED, PLEASE COMPLETE THE FOLLOWING:

PROVIDER NAME _____ FAX NO. _____

ADDRESS _____ CITY _____ PROV. ____ POSTAL CODE _____

Sample Required

- ☐ Blood 2x5 mL EDTA
- ☐ Blood 3 mL EDTA (infant only)
- ☐ DNA ___ug
- ☐ Other _____
- ☐ Cultured Amniocytes
- ☐ Amniotic Fluid 5 mL
- ☐ Cultured CVS
- ☐ CVS

Sample Information

- ☐ **Routine**
- ☐ **Expedited**
  - ☐ Patient/Partner Pregnant
  - ☐ Prenatal Diagnosis
  - ☐ Newborn (less than 3 months of age)

Reason for Test

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

Other family member(s) tested previously:

- ☐ No
- ☐ Yes Name: _____
  CHEO Pedigree number: _____
  Relationship to patient: _____

Test Requested

- ☐ Angelman Syndrome
- ☐ Facioscapulohumeral Muscular Dystrophy (*20 mL in EDTA required*)
- ☐ Factor V Leiden and Factor II Prothrombin
- ☐ Fragile X (FMR1)
- ☐ HFE-related Hemochromatosis
- ☐ Maternal Cell Contamination Studies
- ☐ Myotonic Dystrophy Type I (*ethnic background **must** be specified below*)*
- ☐ 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 if a longer storage term is required)*

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

Additional relevant clinical and/or family history information: