Genetics Diagnostic Laboratory
Standard Cytogenetics Requisition

Blood Work Instructions For Non-CHEO Patients:
Bring requisition to local community lab for blood collection

Sample to be shipped to:
Genetics Diagnostics Laboratory
401 Smyth Road, Rm W3401
Ottawa, ON, K1H 8L1
Tel: (613) 738-3230
Fax: (613) 738-4814
Website: www.cheo.on.ca/GDL

Patient Name: Last: First Initial

Health Card Number:

DOB (yy/mm/dd): **Telephone:**

Address:

Legal Sex: ☐ Male ☐ Female ☐ Unknown

Optional - Sex assigned at birth: ☐ Male ☐ Female ☐ Unknown ☐ Uncertain ☐ Not recorded

Optional - Patient Consent to share results:

Sharing results for family testing: By checking the box below, the patient authorizes CHEO to use their results to guide testing or interpretation for relatives within CHEO's Genetic Diagnostic Lab. Results are used only to inform family member testing decisions. Consent can be changed at any time by contacting the lab. ☐ Patient consents to sharing results with family members

For Lab Use Only – See collection instructions under "Specimen"

Collection Date:	Collection Centre:	Collected By:

Specimen - For more information, see https://www.cheo.on.ca/en/clinics-services-programs/sample-requirements-and-shipping.aspx

☐ Collect in NaHep (green top) tubes 10 mL for adults and children 3 mL for newborns
☐ Peripheral Blood ☐ Cord Blood
☐ Oncology Blood ☐ Bone Marrow
WBC: **Blast%:**

☐ Prenatal
Gestational Age:_____
☐ Twin A ☐ Twin B
☐ Amniotic Fluid
☐ Chorionic Villi
Comments:

☐ Collect in sterile container with sterile culture medium and 1% antibiotics or with sterile isotonic saline solution
☐ Fresh Tissue **Source:**
☐ Skin

☐ Other **Type:** **Source:**

Billing (Non-OHIP / Institutional Only- *Attach Ministry of Health or IFHP approval documentation)

☐ Ministry of Health Approved (e.g. RAMQ)*
☐ Ministry of Health Pending Approval
☐ IFHP Approved*
☐ Non-insured (i.e. self-pay)

☐ Institutional Billing (complete details below)
Institution Name:
City: Province: Postal Code:
Tel: Fax:

Authorizing Health Care Provider(s) - Valid fax number required for all providers

Provider Name:
Registration #:
Address:
Telephone: Fax:

COPY TO
Name:
Fax#
Name:
Fax#

Clinical Indication For more information, see https://www.cheo.on.ca/en/clinics-services-programs/genetic-tests-available.aspx

☐ 3 or more unsuccessful IVF treatment cycles and a diagnosis of unexplained infertility
☐ Primary amenorrhea +/- other feature(s) of sex chromosome abnormality
☐ Primary/premature ovarian insufficiency/failure
☐ 3 or more recurrent clinical miscarriages or pregnancy losses
☐ Sperm abnormalities including azoospermia and severe oligospermia
☐ 1-2 miscarriages with history of infertility
☐ Family history of chromosome abnormality or rearrangement *(Attach a copy of the report. If a copy of the relevant report(s) is not available, please give as much detail as possible in the "Other" field below; however, testing in your patient may be hampered by the absence of familial records due to limitations of tests.)*

Privacy statement: By attaching a copy of the familial report, I attest that my patient/patient's guardian has obtained express consent or I have obtained express consent from their family member/proband for CHEO to use the family member's/proband's report and biological relationship for the purpose of genetic testing and evaluation(e.g. variant is maternally inherited). Consent cannot be withdrawn once the report is complete. No identifiers of the patient will be included in the proband's report, other than the biological relationship. The patient will receive their own report.

☐ Other – **Specify:**

Test(s) Ordered - For more information, see https://www.cheo.on.ca/en/clinics-services-programs/genetic-tests-available.aspx

☐ Chromosome Analysis
☐ Rapid Aneuploidy Detection (RAD) by QF-PCR)
☐ FISH – **specify target(s) of interest** (see our website above for details):
For follow-up of microarray results by FISH, please use the Microarray and Microarray Follow-Up Testing Requisition ***instead***
☐ Tissue culture freeze
☐ Tissue culture hold
☐ Transfer cultured cells to the Molecular Genetics section of the Genetics Diagnostic Laboratory (**attach Molecular Genetics requisition)**
☐ Ship cultured cells **to:**
☐ Ship direct specimen **to:**
For shipment, please attach all requisitions/documentation required by the external laboratory along with shipping information.

GENETICS LAB ONLY **Sample size:** _____ml or mg **Villi Quality:** ☐ Typical ☐ Atypical ☐ Absent
Fluid Quality Clear ☐ Cloudy ☐ Slight Blood ☐ Gross Blood ☐ Discoloured
Pellet Quality ☐ Normal ☐ Tissue ☐ Bloody **Pellet Size:** ☐ S ☐ M ☐ L
COMMENTS:

PED#