Genetics Diagnostic Laboratory
Molecular Genetics Test 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): _____

Address: _____

Telephone: _____

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

Priority of Testing

☐ Routine

Expedited:

☐ Patient/Partner Pregnant
☐ Prenatal Diagnosis
☐ Newborn (≤3 months)

Sample Type (for prenatal/cord blood: separate MCC requisition required; for FSHD: collect same day 4°C)

☐ Blood 2×6 mL EDTA
☐ Blood 3 mL EDTA
☐ Blood 2×3 mL EDTA
☐ Cord blood 3 mL EDTA
☐ DNA _____ µg
source: _____

☐ Cultured Amniocytes 2×T25
☐ Cultured CVS 2×T25
☐ Direct amniotic fluid 20 mL
☐ Direct CVS 10–20 mg
☐ Cultured cells
source: _____

For Lab Use Only

Collection Date: _____

Collection Centre: _____

Collected By: _____

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)

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

COPY TO Name: _____
Registration #: _____
Address: _____
Telephone: _____ **Fax:** _____

Clinical Indication (required–testing will not proceed unless completed)

☐ Symptoms of Indicated Disease

☐ Predictive Testing

☐ Prenatal Diagnosis - this requires a maternal sample with a separate MCC requisition

☐ Carrier Testing (attach family report)
Specify family relationship: _____
Ethnicity: _____ (required for SMA testing)

Privacy statement: By ordering this test, I attest that my patient/patient's guardian has obtained express consent or I have obtained express consent from the family member for CHEO to use the family member's report for the purpose of genetic testing and evaluation.

Test Requested

☐ **HFE-related Hemochromatosis** ☐ **Thrombophilia (Factor V Leiden and Factor II Prothrombin)**
Eligibility for OHIP pts (Hemochromatosis and Thrombophilia): Champlain/N. Ontario. Other pts: Global (No US)

FMR1-related Disorders: ☐ Fragile X Syndrome ☐ POI ☐ FXTAS
Eligibility for OHIP pts (all FMR1-related disorders): Champlain or S/W/N Ontario. Other pts: Global (No US)

☐ **Myotonic Dystrophy Type I**
☐ **Myotonic Dystrophy Type II**
☐ **Angelman Syndrome**
☐ **Prader-Willi Syndrome**

☐ **Oculopharyngeal Muscular Dystrophy (OPMD)**
☐ **Facioscapulohumeral Muscular Dystrophy (FSHD)**
☐ **Spinal Muscular Atrophy (SMA)**

☐ **Maternal Cell Contamination (MCC)**

☐ **DNA Storage (2-year retention)**