



**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](http://www.cheo.on.ca/GDL)

## Genetics Diagnostic Laboratory Molecular Genetics Test Requisition

|                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                  |       |         |
|-----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|---------|
| <b>Patient Name:</b>                                | Last                                                                                                                                                                                                                                                                                                                                                                                                                             | First | Initial |
| <b>Health Card Number:</b>                          |                                                                                                                                                                                                                                                                                                                                                                                                                                  |       |         |
| <b>DOB (yy/mm/dd):</b>                              |                                                                                                                                                                                                                                                                                                                                                                                                                                  |       |         |
| <b>Address:</b>                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                  |       |         |
| <b>Telephone:</b>                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                  |       |         |
| <b>Legal Sex:</b>                                   | <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                   |       |         |
| <b>Optional - Sex assigned at birth:</b>            | <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Uncertain <input type="checkbox"/> Not recorded                                                                                                                                                                                                                                                          |       |         |
| <b>Optional - Patient Consent to share results:</b> | <p><b>Sharing results for family testing:</b> 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.</p> <input type="checkbox"/> Patient consents to sharing results with family members |       |         |

| Priority of Testing                                                                                                                                                                                              | Sample Type (for prenatal/cord blood: separate MCC requisition required; for FSHD: collect same day 4°C)                                                                                                                                             | For Lab Use Only                                                                                                                                                                                                                                                      |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Routine<br><b>Expedited:</b><br><input type="checkbox"/> Patient/Partner Pregnant<br><input type="checkbox"/> Prenatal Diagnosis<br><input type="checkbox"/> Newborn ( $\leq 3$ months) | <input type="checkbox"/> Blood 2x6 mL EDTA<br><input type="checkbox"/> Blood 3 mL EDTA<br><input type="checkbox"/> Blood 2x3 mL EDTA<br><input type="checkbox"/> Cord blood 3 mL EDTA<br><input type="checkbox"/> DNA _____ $\mu$ g<br>source: _____ | <input type="checkbox"/> Cultured Amniocytes 2xT25<br><input type="checkbox"/> Cultured CVS 2xT25<br><input type="checkbox"/> Direct amniotic fluid 20 mL<br><input type="checkbox"/> Direct CVS 10-20 mg<br><input type="checkbox"/> Cultured cells<br>source: _____ |
|                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                      | <b>Collection Date:</b> _____<br><b>Collection Centre:</b> _____<br><b>Collected By:</b> _____                                                                                                                                                                        |

| Billing (Non-OHIP / Institutional Only - *Attach Ministry of Health or IFHP approval documentation)                                                                                                                                  |                                                                                                                                                                                                                        |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Ministry of Health Approved (e.g. RAMQ)*<br><input type="checkbox"/> Ministry of Health Pending Approval<br><input type="checkbox"/> IFHP Approved*<br><input type="checkbox"/> Non-insured (i.e. self-pay) | <input type="checkbox"/> Institutional Billing (complete details below)<br><b>Institution Name:</b> _____<br><b>City:</b> _____ <b>Province:</b> ____ <b>Postal Code:</b> _____<br><b>Tel:</b> _____ <b>Fax:</b> _____ |

| Authorizing Health Care Provider(s)                                                                                               |                                                                                                                                  |
|-----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|
| <b>Provider Name:</b> _____<br><b>Registration #:</b> _____<br><b>Address:</b> _____<br><b>Telephone:</b> _____ <b>Fax:</b> _____ | <b>COPY TO Name:</b> _____<br><b>Registration #:</b> _____<br><b>Address:</b> _____<br><b>Telephone:</b> _____ <b>Fax:</b> _____ |

| Clinical Indication (required-testing will not proceed unless completed)                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Symptoms of Indicated Disease<br><input type="checkbox"/> Predictive Testing<br><input type="checkbox"/> Prenatal Diagnosis - this requires a maternal sample with a separate MCC requisition | <input type="checkbox"/> Carrier Testing (attach family report)<br><b>Specify family relationship:</b> _____<br><b>Ethnicity:</b> _____ (required for SMA testing)<br><b>Privacy statement:</b> 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                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                             |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> <b>HFE-related Hemochromatosis</b> <input type="checkbox"/> <b>Thrombophilia (Factor V Leiden and Factor II Prothrombin)</b><br>Eligibility for OHIP pts (Hemochromatosis and Thrombophilia): Champlain/N. Ontario. Other pts: Global (No US)         |                                                                                                                                                                                                                             |
| <input type="checkbox"/> <b>FMR1-related Disorders:</b> <input type="checkbox"/> Fragile X Syndrome <input type="checkbox"/> POI <input type="checkbox"/> FXTAS<br>Eligibility for OHIP pts (all FMR1-related disorders): Champlain or SW/N Ontario. Other pts: Global (No US) |                                                                                                                                                                                                                             |
| <input type="checkbox"/> <b>Myotonic Dystrophy Type I</b><br><input type="checkbox"/> <b>Myotonic Dystrophy Type II</b><br><input type="checkbox"/> <b>Angelman Syndrome</b><br><input type="checkbox"/> <b>Prader-Willi Syndrome</b>                                          | <input type="checkbox"/> <b>Oculopharyngeal Muscular Dystrophy (OPMD)</b><br><input type="checkbox"/> <b>Facioscapulohumeral Muscular Dystrophy (FSHD)</b><br><input type="checkbox"/> <b>Spinal Muscular Atrophy (SMA)</b> |
| <input type="checkbox"/> <b>Maternal Cell Contamination (MCC)</b>                                                                                                                                                                                                              | <input type="checkbox"/> <b>DNA Storage (2-year retention)</b>                                                                                                                                                              |