



Genetics Diagnostic Laboratory Molecular Genetics Test Requisition

Instructions for Blood Work – Non-CHEO Patients

Please bring this requisition to your local community lab for blood collection.

Sample to be shipped to:

Genetics Diagnostics Laboratory
Room w3401
401 Smyth Road, Rm w3403 Ottawa, ON, K1H 8L1
Tel: (613) 738-3230 Fax: (613) 738-4814
Website: www.cheo.on.ca/GDL

For NON-OHIP Patients: Billing Status (Check One)

- Ministry of Health Approved (approval letter attached)
- Ministry of Health Approval Pending
- IFHP approved (approval letter attached)
- Institution (complete information below)
- Private Pay

INSTITUTIONAL BILLING ONLY

Name: _____
 Address: _____
 Telephone: _____ Fax: _____

Patient Name:

_____ Last _____ First _____ Initial _____

Health Card Number:

DOB (dd/mm/yyyy):

Address:

Telephone:

Sex:

Sex assigned at birth: Male Female

For Lab Use Only:

Collection date:

Collection centre:

Collected by:

- *Blood 2X6mL EDTA
- *Blood 2X3mL EDTA (child)
- *Blood 3mL EDTA (infant ≤1 yr)
- DNA _____ µg, source: _____
- **Cord blood 3mL EDTA
- Direct amniotic fluid 20 mL
- Direct CVS 10-20 mg
- **Cultured Amniocytes 2 x T25 flasks (confluent)
- **Cultured CVS 2 x T25 flasks (confluent)

* For FSHD, collect and ship on the same day at 4°C

**Maternal sample (with separate requisition for MCC) is also required for cord blood and prenatal samples.

Healthcare Provider(s) Requesting Test

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

Priority of testing:

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

Additional relevant clinical and/or family information:

Other family member(s) tested previously? No Yes

Name: _____

Relationship: _____ CHEO Pedigree number: _____

Test Requested and Reason for Testing (required)

Angelman Syndrome: <ul style="list-style-type: none"> <input type="checkbox"/> Symptoms of Indicated Disease <input type="checkbox"/> Carrier Testing <input type="checkbox"/> Prenatal Diagnosis (maternal sample with separate requisition for MCC also required) 	Myotonic Dystrophy Type I: <ul style="list-style-type: none"> <input type="checkbox"/> Symptoms of Indicated Disease <input type="checkbox"/> Predictive Testing <input type="checkbox"/> Prenatal Diagnosis (maternal sample with separate requisition for MCC also required)
Facioscapulohumeral Muscular Dystrophy (FSHD): <ul style="list-style-type: none"> <input type="checkbox"/> Symptoms of Indicated Disease <input type="checkbox"/> Predictive Testing <p><small>For guidance on sample collection and shipment visit our website</small></p>	Myotonic Dystrophy Type II: <ul style="list-style-type: none"> <input type="checkbox"/> Symptoms of Indicated Disease <input type="checkbox"/> Predictive Testing
Thrombophilia (Factor V Leiden and Factor II Prothrombin): <ul style="list-style-type: none"> <input type="checkbox"/> Symptoms of Indicated Disease <input type="checkbox"/> Predictive Testing <p><small>ELIGIBILITY REQUIREMENT FOR OHIP PATIENTS ONLY: must reside in the Champlain or Northern Ontario catchment areas. Samples are otherwise accepted across Canada and Internationally, except for the US</small></p>	Oculopharyngeal Muscular Dystrophy (OPMD): <ul style="list-style-type: none"> <input type="checkbox"/> Symptoms of Indicated Disease <input type="checkbox"/> Predictive Testing
HFE-related Hemochromatosis: <ul style="list-style-type: none"> <input type="checkbox"/> Symptoms of Indicated Disease <input type="checkbox"/> Predictive Testing <p><small>ELIGIBILITY REQUIREMENT FOR OHIP PATIENTS ONLY: must reside in the Champlain or Northern Ontario catchment areas. Samples are otherwise accepted across Canada and Internationally, except for the US</small></p>	Prader-Willi Syndrome (PWS): <ul style="list-style-type: none"> <input type="checkbox"/> Symptoms of Indicated Disease <input type="checkbox"/> Carrier Testing <input type="checkbox"/> Prenatal Diagnosis (maternal sample with separate requisition for MCC also required)
FMR1-related Disorders (select one): <ul style="list-style-type: none"> <input type="checkbox"/> Symptoms of Indicated Disease <input type="checkbox"/> Carrier Testing <input type="checkbox"/> Predictive Testing <input type="checkbox"/> Prenatal Diagnosis (maternal sample with separate requisition for MCC also required) <p><small>ELIGIBILITY REQUIREMENT FOR OHIP PATIENTS ONLY: must reside in Champlain and Southern/Western/Northern Ontario catchment areas. Samples are otherwise accepted across Canada and Internationally, except for the US</small></p>	Spinal Muscular Atrophy (SMA): <ul style="list-style-type: none"> <input type="checkbox"/> Symptoms of Indicated Disease <input type="checkbox"/> Carrier Testing (provide family history and ethnicity, include CHEO Ped# if applicable): _____ <input type="checkbox"/> Prenatal Diagnosis (maternal sample with separate requisition for MCC also required)

Maternal Cell Contamination Studies

DNA Storage (DNA will be stored for 2 years and then discarded)