REQUISITION – Cytogenetic Testing (other than cancer)

Hamilton Regional Laboratory Medicine Program

Juravinski Hospital
Clinical Genetics Laboratory - Room H2-19A
711 Concession Street, Hamilton, ON L8V IC3
Phone: (905) 521-2100 x73707
Email: geneticsmailbox@hhsc.ca

Patient Information Clear Form

***Name** (print):
Surname, First Name
***DOB** (DD/MM/YYYY):

***Sex**: ☐M ☐F ☐Other

***Health Card No.**:

**Mandatory Information. Specimen cannot be processed without this data.*

Note: Specimen collection is NOT completed at this lab. Please proceed to any community lab for blood draw.

Reports To:

*Ordering Physician: _____
*Address: _____
*Phone: _____ *Fax: _____
*Email: _____
*Authorized Signature: _____

Additional Copies To:

*Name: _____
*Address: _____
*Phone: _____
*Fax: _____
*Email: _____

Please see the HRLMP Laboratory Test Information Guide (LTIG) for complete sample requirements and test information:
https://ltig.hrlmp.ca/

SPECIMEN INFORMATION:

Transport at room temperature to the above address. Do not fix, freeze or spin samples.
Transport all tissue samples in a sterile sealed container with sterile transport medium such as MEM.
Collection Date (DD/MM/YYYY): _____ Time of collection: _____
Sample Priority: ☐ Routine ☐ Urgent
Pregnancy at Risk: ☐ No ☐ Yes, gestational age: _____ weeks. Patient's partner's name and DOB: _____

TEST REQUESTED: ***For cytogenetic testing of patients with intellectual disability, neurodevelopmental anomalies, and/or congenital anomalies, please use the MICROARRAY REQUISITION.**

❑ **Chromosome analysis** (G-banding; karyotype) **An indication must be provided (below)**
Please note, Chromosome Analysis is not available for any perinatal tissue samples.
- ☐ Peripheral blood (5-10 mL in sodium heparin, 3 mL in sodium heparin for neonates/infants)
- ☐ Cord blood (>1-2 mL in sodium heparin)
- ☐ Skin or Muscle Biopsy (please circle one)
- ☐ Other (specify): _____

❑ Rule out mosaicism
❑ Freeze cells

****CLINICAL INDICATION** **(Testing cannot proceed without an indication)**
- ☐ Suspected aneuploidy (chr. 13, 18, 21, X, Y)
- ☐ Recurrent miscarriage (≥ 3)
- ☐ Infertility
- ☐ Short stature
- ☐ Amenorrhea
- ☐ Ambiguous genitalia

❑ **FISH**: ☐ DiGeorge/VCF ☐ Other (Contact lab directly): _____

❑ **Family Studies** (Provide HHS Specimen # or attach external lab report): _____
* Contact laboratory directly to discuss sample requirements.

❑ **QF-PCR** (5 mL peripheral blood in EDTA; 1-2 mL in EDTA for neonates/infants)
- ☐ Suspected aneuploidy (chr. 13, 18, 21, X, Y)
- ☐ **Maternal cell contamination studies**. Provide collection date (DD/MM/YYYY): _____
- ☐ Perinatal Tissue (please select all that apply): ☐ Product of Conception ☐ Placenta ☐ Cord Blood ☐ Fetal Skin
  Gestational age: _____ weeks

LAB USE ONLY Tech: Lab No: Received: Specimen Comments: