REQUISITION – Hemoglobinopathy Genetic Testing

Hamilton Regional Laboratory Medicine Program

Juravinski Hospital
Clinical Genetics Laboratory - Room H2-19A
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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: _____

Clinic/Hospital: _____

*Phone: _____ Fax: _____

Email: _____

Physician Signature: _____

Additional Copies To:

*Name: _____

*Clinic/Hospital: _____

*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

Ship at room temperature. Refrigerate at 4°C if overnight or longer storage is unavoidable. Avoid freezing and exposure to excess heat.

Collection Date (DD/MM/YYYY): _____ Time of collection: _____

- ☐ **Peripheral blood** in EDTA (4ml >1 yr/age, 0.5ml <1 yr/age)
- ☐ **DNA** (minimum 1 µg). Source: _____
- ☐ **Cord blood** in EDTA (1-4ml)
- ☐ **Amniotic Fluid** (10-15ml, back up culture required)
- ☐ **Cleaned Chorionic Villi** (5-15mg, back up culture required)
- ☐ **Cultured Cells** (1xT25 confluent flask, back up culture required)

TEST REQUESTED

Please note: CBC, Hemoglobin electrophoresis, and ferritin results are required for processing all hemoglobinopathy samples. Failure to submit these results may result in testing delays.

- ☐ **Hemoglobinopathy:**
  - Ethnicity: _____
  - ☐ Thalassemia
  - ☐ Hemoglobin Variant
  - ☐ Sickle Cell Disease

CLINICAL INDICATION

- ☐ **Symptoms of indicated disease**
- ☐ **Carrier status**
- ☐ **Newborn Screen Positive**
- ☐ **Prenatal diagnosis** (please complete information below)
  - LMP (DD/MM/YY): _____
  - Procedure Date (DD/MM/YY): _____
- ☐ **Family history** (please complete information below)
  - ☐ Patient is proband/index case
  - ☐ Known familial mutation (or HRLMP report #): _____
  - Proband name: _____ DOB (DD/MM/YY): _____ Relationship to patient: _____
- ☐ **Other** (please provide additional details): _____

Urgent/Expedited Cases:
- ☐ Prenatal Diagnosis
- ☐ Newborn Screen Positive
- ☐ Patient Pregnant
- ☐ Partner Pregnant (add information below)
  - Partner Name: _____
  - Partner DOB (DD/MM/YY): _____