REQUISITION – Microarray (Postnatal)

Hamilton Regional Laboratory Medicine Program

Juravinski Hospital
Clinical Genetics Laboratory - Room H2-19A
711 Concession Street, Hamilton, ON L8V 1C3
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 freeze or spin.

☐ Peripheral blood (5-10 mL for adults, 3mL for neonates, in a sterile EDTA collection tube).

* Contact the lab (geneticsmailbox@hhsc.ca) for information regarding submission of other specimen types.

Is this a follow up test? ☐ No ☐ Yes, HHS Specimen #:_____ or **attached report**.
Proband relationship to Patient:_____

Collection Date (DD/MM/YYYY):
_____
Collection Time: _____
Testing Priority:
☐ Routine ☐ Urgent
Is a pregnancy at risk?
☐ No ☐ Yes, GA: _____wks

CLINICAL INFORMATION: Please check all that apply.

Prenatal History:
[ ] Prematurity
[ ] IUGR
[ ] Oligohydramnios or polyhydramnios
[ ] Non-immune hydrops fetalis

Growth:
[ ] Failure to thrive
[ ] Overgrowth
[ ] Short stature
[ ] Other: _____

Cognitive/Developmental:
[ ] Learning disability
[ ] Developmental delay
  [ ] Gross motor delay
  [ ] Fine motor delay
  [ ] Speech delay
[ ] Intellectual disability
[ ] Other: _____

Behavioural/Psychiatric:
[ ] Autism
[ ] Pervasive developmental delay
[ ] Attention deficit hyperactivity disorder
[ ] Anxiety
[ ] Schizophrenia
[ ] IUGR
[ ] Other: _____

Cutaneous:
[ ] Hyperpigmentation/hypopigmentation
[ ] Other: _____

Neurological:
[ ] Seizures
[ ] Hypotonia
[ ] Hypertonia
[ ] Cerebral palsy
[ ] Encephalopathy
[ ] Structural brain anomaly
  Specify: _____
[ ] Other: _____

Cardiac:
[ ] Atrial septal defect
[ ] Ventricular septal defect
[ ] Coarctation of the aorta
[ ] Tetralogy of Fallot
[ ] Other cardiac anomaly : _____

Craniofacial:
[ ] Dysmorphic facial features
  Specify: _____
[ ] Ear malformation
  Specify: _____
[ ] Cleft lip [ ] Cleft palate
[ ] Macrocephaly [ ] Microcephaly
[ ] Other: _____

Hearing/Vision Loss:
[ ] Hearing loss
[ ] Vision abnormality
[ ] Eye movement abnormality
  Specify: _____
[ ] Other: _____

Musculoskeletal:
[ ] Contractures (arthrogryposis)
[ ] Club foot
[ ] Diaphragmatic hernia
[ ] Limb/digit anomaly
  Specify: _____
[ ] Vertebral anomaly
  Specify: _____
[ ] Other: _____

Gastrointestinal:
[ ] Gastroschisis
[ ] Omphalocele
[ ] Anal atresia
[ ] Tracheoesophageal fistula
[ ] Pyloric stenosis
[ ] Other: _____

Genitourinary:
[ ] Ambiguous genitalia
[ ] Hydronephrosis
[ ] Kidney malformation
  Specify: _____
[ ] Cryptorchidism
[ ] Hypospadias
[ ] Other: _____

Family History:
[ ] Parents with ≥ miscarriages
[ ] Other relatives with similar clinical history
  Explain: _____

Other Relevant Clinical Findings: _____

Known Consanguinity: (Y/N), specify _____ **Isolated population ancestry** (Y/N), specify _____ **Homozygosity Information NOT Requested** [ ]*

*This assay can detect regions of homozygosity suggestive of consanguinity. Only use this box if this information is NOT requested.

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