

# REQUISITION – Molecular Diagnostics Requisition



## Juravinski Hospital

Clinical Genetics Laboratory - Room H2-19A  
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## Patient Information

\*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: \_\_\_\_\_  
\*Authorized 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: \_\_\_\_\_

- |                                                                                              |                                                                                            |
|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|
| <input type="checkbox"/> <b>Peripheral blood</b> in EDTA (4ml >1 yr/age, 0.5ml <1 yr/age)    | <input type="checkbox"/> <b>Amniotic Fluid</b> (10-15ml, back up culture required)         |
| <input type="checkbox"/> <b>DNA</b> (minimum 1 µg). Source: _____                            | <input type="checkbox"/> <b>Cord blood</b> in EDTA (1-4ml)                                 |
| <input type="checkbox"/> <b>Cultured Cells</b> (1xT25 confluent flask back up culture req'd) | <input type="checkbox"/> <b>Cleaned Chorionic Villi</b> (5-15mg, back up culture required) |

**TEST REQUESTED** For Hemoglobinopathy testing, see **Hemoglobinopathy Genetic Testing Requisition**.

\* Testing is not offered to individuals with elevated ferritin levels as the sole indication, or to asymptomatic minors [1,2]

- |                                                                            |                                                                                                         |
|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Metachromatic Leukodystrophy (ARSA)               | <input type="checkbox"/> Prothrombin Gene Mutation/Factor V Leiden Genetic Test Panel                   |
| <input type="checkbox"/> Smith-Lemli-Opitz Syndrome (DHCR7)                | <input type="checkbox"/> Quebec Platelet Disorder (PLAU)                                                |
| <input type="checkbox"/> Medium Chain Acyl-Coenzyme Deficiency (ACADM)     | <input type="checkbox"/> Hemochromatosis (HFE) – select from criteria below*:                           |
| <input type="checkbox"/> Very Long Chain Acyl-Coenzyme Deficiency (ACADVL) | [ ] Fasting transferrin saturation >45%                                                                 |
| <input type="checkbox"/> Gamma Polymerase Deficiency (POLG)                | [ ] Family history of C282Y homozygosity                                                                |
| <input type="checkbox"/> Galactosemia (GALT)                               | [ ] Family history of C282Y/H63D compound heterozygosity                                                |
| <input type="checkbox"/> Hyperferritin Cataract Syndrome (FTL)             | * <b>Documentation/reports required</b> ; this can be emailed to                                        |
| <input type="checkbox"/> Thiopurine S-Methyltransferase (TPMT)             | <a href="mailto:moleculargenetics@hhsc.ca">moleculargenetics@hhsc.ca</a> or attached to the requisition |
| <input type="checkbox"/> Bank DNA (for HHS/St. Joseph patients only)       | <input type="checkbox"/> Other (contact lab first): _____                                               |

## CLINICAL INDICATION

- |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                             |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> <b>Symptoms of indicated disease</b>                                                                                                                                                                                                                                           | <b>Urgent/Expedited Cases:</b><br><input type="checkbox"/> Prenatal Diagnosis<br><input type="checkbox"/> Newborn Screen Positive<br><input type="checkbox"/> Patient Pregnant<br><input type="checkbox"/> Partner Pregnant (add information below)<br>Partner Name: _____<br>Partner DOB (DD/MM/YY): _____ |
| <input type="checkbox"/> <b>Carrier status</b>                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                             |
| <input type="checkbox"/> <b>Newborn Screen Positive</b>                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                             |
| <input type="checkbox"/> <b>Prenatal diagnosis</b> (please complete information below)<br>LMP (DD/MM/YY): _____<br>Procedure Date (DD/MM/YY): _____                                                                                                                                                     |                                                                                                                                                                                                                                                                                                             |
| <input type="checkbox"/> <b>Family history</b> (please complete information below)<br><input type="checkbox"/> Patient is proband/index case<br><input type="checkbox"/> Known familial mutation (or HRLMP report #): _____<br>Proband name: _____ DOB (DD/MM/YY): _____ Relationship to patient: _____ |                                                                                                                                                                                                                                                                                                             |
| <input type="checkbox"/> <b>Other</b> (please provide additional details): _____                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                             |