LAB RECEPTION DATE/TIME:

LAB DESCRIPTION:

STAMP OR LABEL HERE

Centre universitaire de santé McGill
McGill University Health Centre

SEND TO: DR. ANDREA RUCHON
MOLECULAR DIAGNOSTIC LABORATORY
E05.3028 LABORATORY CENTRALIZED RECEPTION
1001 DECARIE BLVD, MONTREAL, QC, H4A 3J1
TEL: 514-934-1934 EXT 23383/23298
FAX: TBD
CLIA #: 99D1042152

Montreal Children's Hospital
Molecular Genetics

***SAMPLES CANNOT BE PROCESSED WITHOUT REQUIRED INFORMATION**

PATIENT INFORMATION

1 REQUISITION PER PATIENT

REQUIRED

GENDER: ☐ MALE ☐ FEMALE ☐ UNKNOWN

PATIENT'S NAME:
LEGAL NAME FIRST LAST

DATE OF BIRTH: ☐N/A
MONTH / DAY / YEAR

PROVINCIAL HEALTH #:
CANADA ONLY QUEBEC RESIDENTS RAMQ#

HOSPITAL REF #:

ADDRESS (PATIENT):

FATHER

MOTHER:

ETHNICITY (CHOOSE ALL THAT APPLY):
☐ FRENCH CANADIAN (SELECT REGION IF RELEVANT)
☐ SAGUENAY-LAC-ST-JEAN ☐ CHARLEVOIX ☐ _____
☐ ASHKENAZI JEWISH
☐ OTHER (PLEASE SPECIFY):_____

PEDIGREE/CLINICAL INFORMATION (PLEASE COMPLETE)

☐ ONGOING PREGNANCY INVOLVED

GESTATIONAL AGE: _____ WEEKS ON ____ / ____ / 20__ ☐LMP ☐US
MONTH DAY YEAR

IF OTHER SAMPLES SUBMITTED INDICATE NAME/DOB & RELATIONSHIP TO PATIENT.

DRAW ON BACK OR ATTACH PEDIGREE IF NECESSARY

PREVIOUSLY TESTED FAMILY MEMBERS LAB FAMILY #: _____

NAME(S): _____

MUTATION(S) ☐ UNKNOWN ☐ KNOWN (SPECIFY)_____

PHYSICIAN INFORMATION (REQUIRED)

REQUIRED

PHYSICIAN'S NAME:

LICENSE #:

INSTITUTION:

ADDRESS:

PHONE: ***FAX:***

GENETIC COUNSELLOR:

PHONE: FAX:

PHYSICIAN/GENETIC COUNSELLOR

SIGNATURE: _____ ***DATE:*** _____
MONTH/DAY/YEAR

I ACKNOWLEDGE THAT THE PATIENT/GUARDIAN ARE AWARE OF THE BENEFITS, LIMITATIONS & RISKS ACCOCIATED WITH THE REQUESTED TEST(S) AND THAT I HAVE OBTAINED INFORMED CONSENT TO PERFORM GENETIC TESTING FOR THIS PATIENT.

TEST REQUESTED (REQUIRED)

☐ CFTR-RELATED DISORDERS (SELECT ALL THAT APPLY)

SWEAT CHLORIDE VALUES: ☐UNAVAILABLE ☐NO ☐YES (RESULT_____)

☐ FETAL ECHOGENIC BOWEL ☐ CAVD/CBAVD
☐ PANCREATIC INSUFFICIENCY ☐ FAILURE TO THRIVE ☐ MECONIUM ILEUS
☐ CHRONIC PANCREATITIS ☐ BRONCHIECTASIS ☐ ASTHMA
☐ SINUSITIS ☐ RECTAL PROLAPSE ☐ NASAL POLYPS
☐ RESPIRATORY INFECTION (SPECIFY) _____

OTHER: _____

☐ ANGELMAN SYNDROME ☐ METHYLATION ☐ UPD15
☐ PRADER-WILLI SYNDROME ☐ METHYLATION ☐ UPD15
☐ ASHKENAZI JEWISH PANEL (FAMILIAL DYSAUTONOMIA/TAYSACHS/CANAVAN)
☐ DEAFNESS (CONNEXIN26/30)
☐ CLOUSTON (HED2)
☐ MCAD DEFICIENCY
☐ PAH DEFICIENCY ☐PKU ☐HYPERPHENYLALANINEMIA
☐ TAY-SACHS ENZYMES: ☐ NO ☐ YES (PLEASE ATTACH RESULTS)
☐ UPD15
☐ Y-CHROMOSOME MICRODELETIONS
☐ HBB-RELATED DISORDERS* (SELECT ALL THAT APPLY)
☐HbS ☐HbC ☐HbE OTHER:_____
β –THALASSEMIA: ☐MAJOR ☐INTERMEDIA ☐TRAIT/MINOR
* INCLUDE RELEVANT LAB FINDINGS (EG. CBC;ELECTROPHORESIS;HPLC)

SAMPLE INFORMATION (REQUIRED)

LABORATORY RECEPTION HOURS: MON-FRI 8:00-16:00
PRENATAL SAMPLES MON-THR 8:00 - 16:00

COLLECTION DATE ____ / ____ / 20__ ***TIME:*** _____ ***AM / PM***
MONTH DAY YEAR

BLOOD (EDTA/LAVENDER) ☐ 2cc NEWBORN ☐ 5cc ADULT

PRENATAL *(CONTACT LAB FOR INSTRUCTIONS)*

☐ AMNIOTIC FLUID ☐ CULTURED AMNIOCYTES ☐ CVS min 10 mg (DIRECT)

DNA : SOURCE _____ CONC. _____ (/)

OTHER (SPECIFY): _____

EACH SAMPLE MUST BE LABELLED WITH THE PATIENT'S NAME AND DOB. IF BLOOD SAMPLES CANNOT BE SHIPPED THE SAME DAY STORE AT 4°C. DO NOT FREEZE. BLOOD TUBES SHOULD BE PROPERLY PACKAGED TO PROTECT AGAINST SHOCK AND DAMAGE.

INDICATION FOR TESTING (REQUIRED)

☐ CONFIRM CLINICAL DIAGNOSIS
☐ POSITIVE NEWBORN SCREENING
☐ CARRIER STATUS (ASYMPTOMATIC)
☐ FAMILY HISTORY (PLEASE INDICATE RELATIONSHIP IN PEDIGREE)
☐ OTHER (SPECIFY REASON)_____
☐ PRENATAL DIAGNOSIS (MATERNAL SAMPLE REQUIRED)
☐ MATERNAL CELL CONTAMINATION STUDIES
☐ OTHER (SPECIFY) _____

REQUIRED INFORMATION