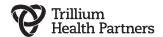


## THP MICROARRAY TEST REQUISITION

GENETICS LABORATORY - Credit Valley Hospital
2200 Eglinton Ave. W., Rm 2H144 Tel: (905) 813-1100 x6288
Mississauga, ON L5M 2N1 Canada Fax: (905) 813-3854

Patient Acct No.						
Patient Name (Surname First)						
Patient Unit No.						
D.O.B.	Sex					
Address/City/Province/Postal Code						
Health Card Num	ber	Version	□ WCB			
			☐ SELF PAY			

				□ SELF		
С	omplete in full to avoid	delay in rep	oorting result.			
PHYSICIAN INFORMATION						
Referring Physician:		Copy To: _				
Registration #:			n #:			
Address:		Address: _				
Phone: Fa	ax:	Phone:				
Signature (required):		Fax:				
SPECIMEN COLLECTION: DA	ATE:	-	TIME:			
	ATE:			нн:мм		
	TEST RE	QUESTED				
DIAGNOSTIC Testing			Relevant Family	v History:		
Specimen Requirements			(at least 3-generation, when	' ' I		
Peripheral Blood in <b>EDTA</b> (3)	mL minimum) (1mL min for	newborns)		,		
☐ Fibroblast Cell Culture: 2x T	* *	,				
☐ Extracted DNA: 2ug total (minimum concentration of 70 ng/uL)						
		<b>J</b> • /				
Indications for Testing:						
☐ Developmental Delay or Intel	llectual Disability					
☐ Developmental Delay or Intellectual Disability & additional clinical features.  Complete Clinical Description Form (page 2)						
☐ Two or more congenital anomalies.  Complete Clinical Description Form (page 2)						
Karyotype (if known):						
FOLLOW-UP Studies						
<u>Specimen Requirements</u> (in proba	nd report):	Follow-Up I	nformation:			
☐ FISH Follow-Up Studies - <b>N</b> a	aHep blood, 3mL min.	Family ID#	(in proband report):			
☐ Q-PCR Follow-Up Studies -	EDTA blood, 3mL min.		Proband:			
Date Recieved (DD/MM/YYYY):		Time:	Specimen Re	c'd:		
Comments:						
Unit #:		LAB #:				



## MICROARRAY CLINICAL DESCRIPTION FORM

GENETICS LABORATORY - Credit Valley Hospital
2200 Eglinton Ave. W., Rm 2H144 Tel: (905) 813-1100 x6288
Mississauga, ON L5M 2N1 Canada Fax: (905) 813-3854

Patient Acct No.				
Patient Name (Surname First)				
Patient Unit No.				
D.O.B. Sex				
Address/City/Province/Postal Code				
Health Card Number	Version			

## Phenotypic description (Clinical symptoms)