Trillium Health Partners
Credit Valley Hospital

PRENATAL MICROARRAY REQUISITION

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

Acct # _____

Last Name: _____

First Name: _____

DOB: _____(DD/MM/YYY) Sex: _____

Healthcard #: _____ VC: _____

Address: _____

_____

Primary Phone #: _____

Unit # _____

To ensure there is no delay in reporting results; please ensure the following accompany each sample:

- ☐ Completed requisition form
- ☐ Parental samples. *Mother's sample is mandatory for MCC studies. Father's sample is highly recommended (Complete a Separate Prenatal Microarray Requisition for each parent)*

PHYSICIAN INFORMATION

Referring Dr: _____

Registration #:_____

Address: _____

Telephone:_____ Fax:_____

Signature *(required):* _____

Copy To:_____

Registration #:_____

Address:_____

Telephone:_____ Fax:_____

CLINICAL INFORMATION

Gestation at collection date: _____weeks

Karyotype result (if known) : _____

Sex of Fetus (if known): _____

(by ☐ QF-PCR *or* ☐ FISH)

Father's name: _____ *DOB:* _____

Please attach pedigree if relevant

INDICATION FOR TESTING:

☐ Fetal Ultrasound Abnormality
(please specify below and attach copy of fetal ultrasound)

- ☐ Brain malformation: _____
- ☐ Facial cleft: _____
- ☐ Heart defect: _____
- ☐ Lung abnormality:_____
- ☐ Diaphragmatic hernia: _____
- ☐ GI abnormality:_____
- ☐ GU abnormality:_____
- ☐ Skeletal abnormality: _____
- ☐ NT greater than or equal to 3.5mm: _____
- ☐ Other: _____

☐ Known familial microarray deletion/duplication syndrome
(provide copy of the result)

SPECIMEN TYPE

- ☐ Direct CVS (10-15 mg cleaned villi)
- ☐ Cultured CVS (1 T75 or 2 T25 flasks 70% confluent)
- ☐ Direct Amniotic Fluid (15cc)
- ☐ Cultured Amniocytes (1 T75 or 2 T25 flasks 70% confluent)
- ☐ DNA: 2ug total (at a minimum concentration of 70 ng/uL)
- ☐ Other: _____

Parental Sample:

- ☐ Maternal Blood: 5-10mL EDTA
- ☐ Paternal Blood: 5-10mL EDTA

SPECIMEN COLLECTION:

Date: _____ (DD/MM/YYYY)

Time: _____

CVH Lab Use Only

Date Rec'd:(DD/MM/YYYY) _____ Time: _____ # Tubes Rec'd: _____

Comments: _____

Unit # **LAB #**

3993 D HR (July/2013)