Trillium Health Partners

THP MOLECULAR DIAGNOSTIC LABORATORY REQUISITION

GENETICS LABORATORY – Credit Valley Hospital

2200 Eglinton Ave. W., Rm 2H144
Mississauga, ON L5M 2N1

Telephone: (905) 813-1100 x6288
Fax Number: (905) 813-3854

Account Number: _____ Unit Number: _____

Patient Name: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female

Healthcard Number: _____ Version: _____ ☐ WCB ☐ SELF PAY

Street Address: _____

City: _____

Postal Code: _____ Home Phone: _____

Complete in full to avoid delay in reporting result

PHYSICIAN INFORMATION

Referring Dr: _____

Registration Number: _____

Address: _____

Telephone: _____ Fax: _____

Signature (required): _____

Copy To: _____

Registration Number: _____

Address: _____

Telephone: _____ Fax: _____

SPECIMEN COLLECTION DATE (DD/MM/YYYY): _____ **Time (HH:MM):** _____

Specimen Submitted:

☐ Blood, 5-10 mL **EDTA** Room Temperature ☐ DNA (5µg minimum) ☐ Products Of Conception (Fresh Only; No Formalin)

☐ Amniotic Fluid ☐ Cultured Amniocytes ☐ Tissue (fresh) source: _____

Other Information:

Ethnic background: _____ Pregnant? Last Mentrual Period: _____

Index case: ☐ Yes ☐ No

Name of index case: _____ Relationship: _____

~ Please attach pedigree with any additional clinical information ~

TEST REQUESTED

Blood Disorders ☐ Hemochromatosis ☐ Thrombophilia (Factor V, Prothrombin)

COPD or Liver Disease

☐ Alpha-1- *SERPINA1 (A1AT)* sequencing Patient Symptomatic? ☐ Yes ☐ No ☐ Carrier testing

Serum A1AT activity: _____ g/L *If yes, specify:* ☐ Lung disease / ☐ Liver disease ☐ Confirm Diagnosis

Inherited Cancer ☐ **Patient needs STAT testing for treatment decisions**

Next Generation Sequencing Panels (includes deletion/duplication analysis)

☐ Hereditary Cancer – Breast/Ovarian; Risk Category Number _____ ☐ Private Mutation (attach documentation)

☐ Hereditary Cancer – Colorectal/Gastric ☐ Founder Mutations ☐ Ashkenazi Jewish

☐ Hereditary Cancer – Pancreatic ☐ Portuguese (Alu)

☐ Hereditary Cancer – Comprehensive; Risk Category Number _____ ☐ Other _____

Pre/Perinatal and Sex Typing

☐ Sex Determination Aneuploidy Testing ☐ Fetal Demise ☐ Prenatal

☐ Uniparental Disomy: Chromosome _____ : Karyotype ☐ Neonatal (chr 13 / 18 / 21) *circle one*

DNA Extraction

☐ Banking: Short Term Long Term

LAB USE ONLY

Date Received (DD/MM/YYY): _____ Time: _____ Specimen Received: _____

Comments: _____

MRN: _____ **LAB Number:** _____