Genetics Laboratory – Credit Valley Hospital
2200 Eglinton Avenue West, Room 2H144
Mississauga, ON L5M 2N1
Tel: (905) 813-1100 ext.81-6288
Fax: (905) 813-3854

Trillium Health Partners

CONSTITUTIONAL CYTOGENETICS TESTING REQUISITION

~ Visit community collection lab for blood draw ~

PATIENT DEMOGRAPHICS

Last Name:
First Name:
Address:
City:
Province:
Postal Code:
Health Card #:
Date of Birth (DD/MM/YYYY):
Legal Sex: ☐ Male ☐ Female ☐ Non-Binary ☐ Unknown ☐ X
Sex Assigned at Birth: ☐ Male ☐ Female ☐ Uncertain ☐ Unknown ☐ Choose not to disclose

REFERRING PROVIDER

Last Name:
First Name:
CPSO #: OHIP Billing #:
Address:
City:
Province: Phone #:
Postal Code: Fax #:
Signature (required):

COPIES TO

Last Name:
First Name:
CPSO #: OHIP Billing #:
Address:
City:
Province:
Postal Code:
Phone #: Fax #:

SPECIMEN REQUIREMENTS

☐ Blood (3mL NaHep; 1mL for neonates) room temp
☐ Skin Biopsy (sterile media; no gauze) Source: _____

SPECIMEN COLLECTION

Collection Date (dd/mm/yyyy): _____
Collection Time: _____

CLINICAL INFORMATION

☐ Pregnant? Gestation: _____
☐ Egg Donor?

ADDITIONAL NOTES

FAMILY HISTORY

Index Case: ☐ Y ☐ N
Relationship to Index Case:
Name of Index Case:
MRN / HC# of Index Case:
Please attach relevant personal / family history.

THP LABORATORY USE ONLY

Date/Time Received/ Tech:
Specimen Details:
Comments:
RQ#:

For THP LABEL ONLY

Trillium Health Partners

Last Name:
First Name:
Health Card #:
Date of Birth:

CONSTITUTIONAL CYTOGENETICS TESTING REQUISITION

Reproductive Health – Karyotype Analysis

Infertility Indications
☐ ≥ 3 unsuccessful in-vitro fertilization (IVF) treatment cycles and a diagnosis of unexplained infertility
☐ ≥ 3 recurrent clinical miscarriages or pregnancy losses
☐ ≥1 miscarriages with history of infertility
☐ Primary amenorrhea
☐ Premature Ovarian Insufficiency
☐ Sperm abnormalities including azoospermia and severe oligospermia
☐ Other *Specify:*

Other Cytogenetic Indications – Karyotype Analysis

Indications
☐ Turner syndrome *
☐ Klinefelter syndrome *
☐ Ambiguous genitalia / Sex Chromosome Determination *
☐ Neonatal death *
☐ Trisomy * *Specify chromosome of interest (chromosome 13,18 or 21):* _____
☐ History of Stillbirth
☐ Ring Chromosome 20 study (epilepsy patients)
☐ Family History of Chromosomal Abnormality *[Please attach family reports]* *Specify:*
☐ Other *Specify:*

* Note: If clinical suspicion for a genomic imbalance—particularly in the context of developmental differences or congenital anomalies—chromosomal microarray analysis is recommended as the first-line investigation. If clinically indicated, please submit a sodium heparin peripheral blood specimen with a completed requisition for microarray testing.
See https://www.thp.ca/patientservices/genetics/Pages/requisitions-forms.aspx.