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

MICROARRAY GENETICS 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

☐ Extracted DNA (2µg total; min 70ng/uL)
Source:

☐ Amniotic Fluid Gestational Age:

☐ Cultured Amniocytes Gestational Age:

☐ Products of Conception (No formalin; Placenta not accepted)
Gestational Age (if known):

SPECIMEN COLLECTION

Collection Date (DD/MM/YYYY):
Collection Time:

TEST REQUIRED

☐ Diagnostic Microarray *-complete section 1*

☐ Follow-Up Microarray Family Studies *-complete section 2*

Available Tests for *THP Genetics Clinic* Only:

☐ Microarray Region-Specific Analysis (RSA), Abnormal Prenatal Cell-free Screen Chromosome(s): _____

☐ Uniparental Disomy (UPD) Region-Specific Analysis (RSA) Studies Chromosome(s): _____
NOTE: Both parents & proband samples are required

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.

CLINICAL INFORMATION

☐ Pregnant? EDD:

☐ Egg Donor?

TESTING STATUS

☐ Routine

☐ Expedited *Reason (required):*

ADDITIONAL NOTES

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:

MICROARRAY GENETICS TESTING REQUISITION

Section 1: Diagnostic Testing

CLINICAL INDICATION	FAMILY HISTORY
☐ Developmental Delay ☐ Intellectual Disability ☐ Two or more congenital anomalies	☐ Parents ≥ 3 miscarriages ☐ Consanguinity List Family Health Conditions (describe relationship with proband):

The 'Phenotypic Description' section below MUST be completed for accurate interpretation.

PHENOTYPIC DESCRIPTION (Clinical Symptoms)

Behavior, Cognition and Development
- ☐ Global development delay
- ☐ Gross motor delay
- ☐ Fine motor delay
- ☐ Language delay
- ☐ Learning disability
- ☐ Intellectual disability
  - ☐ Mild
  - ☐ Moderate
  - ☐ Severe
- ☐ Attention deficit hyperactivity disorder
- ☐ Autism Spectrum Disorder
- ☐ Psychiatric disorders
- ☐ Other *specify below**

Neurological
- ☐ Hypotonia
- ☐ Seizures
- ☐ Ataxia
- ☐ Dystonia
- ☐ Chorea
- ☐ Spasticity
- ☐ Cerebral palsy
- ☐ Neural tube defect
- ☐ Central Nervous System Abnormality *specify below**
- ☐ Other *specify below**

Growth Parameters

	Less than	Greater than
Weight for age:	☐ 3rd %	☐ 97th %
Height for age:	☐ 3rd %	☐ 97th %

- ☐ Hemihypertrophy
- ☐ Other *specify below**

Cardiac
- ☐ Atrial septal defect
- ☐ Ventricular septal defect
- ☐ Atrioventricular canal defect
- ☐ Coarctation of aorta
- ☐ Tetralogy of Fallot
- ☐ Other *specify below**

Craniofacial
- ☐ Craniosynostosis
- ☐ Cleft lip
- ☐ Cleft palate
- ☐ Facial dysmorphism
- ☐ Macrocephaly
- ☐ Microcephaly
- ☐ Micrognathia
- ☐ Retrognathia
- ☐ Other *specify below**

Eye Defects
- ☐ Blindness
- ☐ Coloboma
- ☐ Epicanthus
- ☐ Hypertelorism
- ☐ Eyelid abnormality *specify below**
- ☐ Other *specify below**

Ear Defects
- ☐ Deafness
- ☐ Preauricular
- ☐ Low-set ears
- ☐ Outer ear abnormality specify below*
- ☐ Inner ear abnormality *specify below**
- ☐ Other *specify below**

Genitourinary
- ☐ Kidney malformation *specify below*
- ☐ Hydronephrosis
- ☐ Ambiguous genitalia
- ☐ Hypospadias
- ☐ Cryptorchidism
- ☐ Other *specify below**

Respiratory
- ☐ Diaphragmatic hernia
- ☐ Lung abnormality *specify below**
- ☐ Other *specify below**

Musculoskeletal
- ☐ Upper limb abnormality
- ☐ Lower limb abnormality
- ☐ Camptodactyly ☐ Fingers ☐ Toes
- ☐ Syndactyly ☐ Fingers ☐ Toes
- ☐ Polydactyly ☐ Fingers ☐ Toes
- ☐ Preaxial
- ☐ Postaxial
- ☐ Oligodactyly
- ☐ Clinodactyly
- ☐ Contractures
- ☐ Scoliosis
- ☐ Vertebral Anomaly
- ☐ Club foot
- ☐ Other *specify below**

Gastrointestinal
- ☐ Esophageal atresia
- ☐ Tracheoesophageal fistula
- ☐ Gastroschisis
- ☐ Omphalocele
- ☐ Pyloric stenosis
- ☐ Other *specify below**

Cutaneous
- ☐ Hyperpigmentation
- ☐ Hypopigmentation
- ☐ Other *specify below**

* Clinical Details:

PRENATAL AND PERINATAL HISTORY

- ☐ Intrauterine growth restriction
- ☐ Oligohydramnios
- ☐ Polyhydramnios
- ☐ Premature birth
- ☐ EFTS/NIPT Screen Positive *Result:*
- ☐ Fetal soft markers in obstetric ultrasound *Specify:*
- ☐ Fetal structural abnormality

Section 2: Follow-Up Family Testing

Proband Report Lab #: Family ID #: Relationship to Proband:

Indicate if a family member will not be providing bloodwork to prevent test delay:

Follow-Up test methodology will be performed based on lab protocol and discretion.