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

MOLECULAR GENETICS DIAGNOSTIC 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 (5-10mL EDTA; 1mL neonates) room temp
☐ Amniotic Fluid *Gestational Age:*
☐ Cultured Amniocytes *Gestational Age:*
☐ Extracted DNA (2µg total; min 70ng/uL)
Source:
☐ Products of Conception (No formalin; Placenta not accepted)
Gestational Age (if known):

SPECIMEN COLLECTION

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

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):*
Surgery Date (if applicable):

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:

MOLECULAR GENETICS DIAGNOSTIC TESTING REQUISITION

ANEUPLOIDY TESTING / SEX CHROMOSOME DETERMINATION

- ☐ Ambiguous genitalia / Sex Chromosome Determination
- ☐ Fetal Demise / Products of Conception
- ☐ Postnatal *Specify Chromosome of interest (13, 18, 21, X, Y):* _____
- ☐ Prenatal *Gestation:* _____
- ☐ Maternal Cell Contamination (MCC) studies

BLOOD DISORDERS

- ☐ Hemochromatosis (*HFE*) Common Variants
- ☐ Thrombophilia Common Variant Panel (Factor II, Factor V)

COPD or LIVER DISEASE

☐ Alpha-1 Antitrypsin *SERPINA1* (A1AT) Whole Gene Sequencing

Patient's Serum A1AT Activity: _____ g/L

☐ Lung Disease ☐ Liver Disease ☐ Asymptomatic
☐ Carrier Testing ☐ Other: _____

PHARMACOGENOMICS

- ☐ *DPYD*
- ☐ *NUDT15* and *TPMT*

FAMILIAL HYPERCHOLESTEROLEMIA

Please complete *Familial Hypercholesterolemia Testing Requisition* *

HEREDITARY CANCER PANEL

Please complete *Molecular Genetics Hereditary Cancer Panel Testing Requisition* *

* https://www.thp.ca/patientservices/genetics/Pages/requisitions-forms.aspx

AVAILABLE TESTS FOR *THP GENETICS CLINIC* ONLY

DNA BANKING

- ☐ Short-Term Storage (2 years)
- ☐ Long-Term Storage (25 years)

SEND-OUT BLOOD WORK

☐ Send-Out Testing Laboratory: _____ Test Request: _____

Note to Ordering Clinician: *Ensure completed Send-Out requisition has already been forwarded to the Genetics Lab.*