Medical Genetics Laboratory Constitutional Cytogenetics Requisition

Craig L Dobbin Research Centre, Room 3M500
300 Prince Philip Drive, St. John's, NL, A1B 3V6
Telephone: (709) 777-4532 Fax: (709) 777-4792

IV1800 0764 12 2013

COMPLETE ALL SECTIONS. Incomplete requisitions will delay testing.

Patient Information:

Name: _____ _____
Last First

HCN: _____

Date of Birth: _____ DD/MONTH/YYYY

Sex: ☐ Male ☐ Female

Previously tested family members? ☐ Yes ☐ No

Index Case: _____

Referring Physician:

Name: _____ (Print Clearly)

Address: _____

City: _____ Province: _____

Telephone: _____ Fax: _____

Signature: _____ Date: DD/MONTH/YYYY

Copy to: _____

I. Specimen Requirements:

Peripheral Blood collected at room temperature in sodium heparin dark green top tube

☐ Adults - Children - 4-8 mL
☐ Infants - 2-4 mL

Tissue in sterile RPMI/Hanks/Saline (minimum 3 X 5 mm)
Specimen Collection:
Date: DD/MONTH/YYYY Time: HH:MM
Location: _____ Initials: _____

☐ Skin
☐ Cartilage
☐ Placenta
☐ POC

II. Testing Requested - REQUIRED (check all that apply)

☐ Karyotype (Include indication for testing below)

Indication for Testing:

☐ Down Syndrome ☐ Klinefelter Syndrome
☐ Trisomy 13 ☐ Turner Syndrome
☐ Trisomy 18
☐ Greater than 2 miscarriages **OR** ☐ Stillbirth
(collect blood at least 8 weeks post birth)
☐ Infertility (details: _____)
☐ Amenorrhea
☐ Premature Menopause
☐ IVF Treatment Pending
☐ Azoospermia/Oligospermia
☐ Family history of chromosome rearrangement
(details: _____)
☐ Prenatal detection of chromosome rearrangement
(details: _____)

Patient currently pregnant? ☐ Yes ☐ No

☐ Multiple Congenital Malformations
☐ Dysmorphic Facies
☐ Ambiguous Genitalia
☐ Intellectual Disability/Developmental Delay
☐ Delayed Puberty
☐ Short Stature
☐ Fanconi Anemia
☐ Other: _____

FISH:

☐ X centromere/SRY (Yp11.3)
☐ Digeorge/VCFS Syndrome (22q11.2)
☐ Smith-Magenis Syndrome (17p11.2)
☐ Wolf-Hirschhorn Syndrome (4p16)
☐ Williams Syndrome (7q11.23)
☐ Prader-Willi/Angelman Syndrome (15q11.2)
☐ post-BMT Monitoring by XX/XY FISH
☐ Other: _____

Microarray Follow up FISH:

☐ Proband ☐ Family Member

Relationship: _____

Copy number change: _____

Lab number: _____

FOR LABORATORY USE:

GE Number: _____

Amount Received: _____

Date Received: _____ DD/MONTH/YYY

Date Set up: _____ DD/MONTH/YYY

Name: _____

Signature: _____

Comments:

Name: _____ Signature: _____ Date: DD/MONTH/YYYY