CYTOGENETIC REQUISITION (OTHER THAN CANCER)

HAMILTON HEALTH SCIENCES
Hamilton Regional Laboratory Medicine Program
Regional Cytogenetics Laboratory, Room 3H45
McMaster University Medical Centre
1200 Main St. W., Hamilton Ontario L8N 3Z5
Office: 3N14 (905) 521-2100 Ext. 73707

Patient Information

***Name** (print)
Surname, First Name
Address
***DOB** (DD/MM/YY)
***Sex M [ ] F [ ]**
***Health Card No.:**

***Mandatory Information**: (Specimen cannot be processed without this data)

REPORTS TO:	Additional Copies to:	DATE SAMPLE TAKEN:
Ordering Physician:_____ * Surname, First Name Address:_____ *Phone: _____ Fax:_____ Physician Signature:_____	Name:_____ *Surname, First Name Address:_____ *Phone: _____ Fax:_____	(DD/MM/YY): Ward/Hospital where sample taken:

Specimen Submission
Transport at room temperature to the above address.
Do not fix, freeze or spin samples.
Transport all tissue samples in a sterile sealed container with sterile transport medium such as MEM.
***For indications of developmental delay, multiple congenital anomalies, autism or intellectual disability, please use the MICROARRAY REQUISITION.**

Sample Information:
❑Routine ❑ Urgent

Is a pregnancy at risk?
❑No ❑ Yes: Gestational age _____ wks

TESTING REQUESTED: Please see the HRLMP Laboratory test information guide for complete sample requirements http://www.ltig.hrlmp.ca/

❑ **Chromosome analysis** (G-banding; karyotype) **An indication must be provided (below)**
- ❑ Peripheral blood (5-10 mL in sodium heparin, 3 mL in sodium heparin for neonates/infants)
- ❑ Cord blood (>1-2 mL in sodium heparin)
- ❑ Tissue (specify) _____ Gestational age if applicable _____wks
- ❑ Other (specify)

❑ Rule out mosaicism
❑ Freeze cells

****CLINICAL INDICATION (Testing can not proceed without an indication)**
[ ] Suspected aneuploidy (chr. 13, 18, 21, X, Y)
[ ] Recurrent miscarriage (≥ 3)
[ ] Infertility
[ ] Short stature
[ ] Amenorrhea
[ ] Ambiguous genitalia

FISH: ❑ DiGeorge/VCF ❑ Williams ❑ Smith-Magenis ❑ Other (Contact lab directly) _____

❑ **Family Studies** (Provide HHS Specimen # or attach external lab report) _____
Contact laboratory directly to discuss sample requirements.

❑ **QF-PCR** (5 mL peripheral blood in EDTA; 1-2 mL in EDTA for neonates/infants)
[ ] Suspected aneuploidy (chr. 13, 18, 21, X, Y)
[ ] Maternal cell contamination studies. Provide procedure date: _____

LAB USE ONLY
TECH: LAB NO: RECEIVED:
COMMENTS ON SPECIMEN: