REQUISITION – Hemoglobinopathy Genetic Testing

Hamilton Regional Laboratory Medicine Program

Juravinski Hospital
Clinical Genetics Laboratory - Room H2-19A
711 Concession Street, Hamilton, ON L8V IC3
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Patient Information

*__Name__ (print):
Surname, First Name

*__DOB__ (DD/MM/YYYY):

*__Sex__: ☐M ☐F ☐Other

*__Health Card No.__:

**Mandatory Information. Specimen cannot be processed without this data.*

Note: Specimen collection is NOT completed at this lab. Please proceed to any community lab for blood draw.

Reports To:

*Ordering Physician: ____________________________
Clinic/Hospital:________________________________
*Phone: __________________ Fax:________________
Email: ____________________
Physician Signature: ______________________________

Additional Copies To:

*Name: ________________________________
*Clinic/Hospital: _________________________
*Phone: _______________________________
*Fax: _________________________________
*Email: ________________________________

Please see the HRLMP Laboratory Test Information Guide (LTIG) for complete sample requirements and test information:
https://ltig.hrlmp.ca/

SPECIMEN INFORMATION

Ship at room temperature. Refrigerate at 4ºC if overnight or longer storage is unavoidable. Avoid freezing and exposure to excess heat.

Collection Date (DD/MM/YYYY): ________________ Time of collection: ________________

☐ **Peripheral blood** in EDTA (4ml >1 yr/age, 0.5ml <1 yr/age)
☐ **DNA** (minimum 1 µg). Source: _____________
☐ **Cord blood** in EDTA (1-4ml)
☐ **Amniotic Fluid** (10-15ml, back up culture required)
☐ **Cleaned Chorionic Villi** (5-15mg, back up culture required)
Cultured Cells (1xT25 confluent flask, back up culture required)

TEST REQUESTED

Please note: <u>CBC, Hemoglobin electrophoresis, and ferritin results are required</u> for processing all hemoglobinopathy samples. Failure to submit these results may result in testing delays.

☐ **Hemoglobinopathy:**
Ethnicity:____________________________
☐ Thalassemia
☐ Hemoglobin Variant
☐ Sickle Cell Disease

CLINICAL INDICATION

☐ **Symptoms of indicated disease**
☐ **Carrier status**
☐ **Newborn Screen Positive**
☐ **Prenatal diagnosis** (please complete information below)
LMP (DD/MM/YY): _________________
Procedure Date (DD/MM/YY): _________________
☐ **Family history** (please complete information below)
☐ Patient is proband/index case
☐ Known familial mutation (or HRLMP report #): ______________________
Proband name: ____________________ DOB (DD/MM/YY): ___________ Relationship to patient: ______________
☐ **Other** (please provide additional details): ____
____

Urgent/Expedited Cases:
☐ Prenatal Diagnosis
☐ Newborn Screen Positive
☐ Patient Pregnant
☐ Partner Pregnant (add information below)
Partner Name: ______________________
Partner DOB (DD/MM/YY): ____________