REQUISITION – Molecular Diagnostics Requisition

Hamilton Regional Laboratory Medicine Program

Juravinski Hospital
Clinical Genetics Laboratory - Room H2-19A
711 Concession Street, Hamilton, ON L8V IC3
Phone: (905) 521-2100 x76944 | Fax: (905) 521-7913
Email: moleculargenetics@hhsc.ca

Patient Information

Clear Form

*__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: _____
*Authorized 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 4°C 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: _____
- ☐ **Cultured Cells** (1xT25 confluent flask back up culture req'd)
- ☐ **Amniotic Fluid** (10-15ml, back up culture required)
- ☐ **Cord blood** in EDTA (1-4ml)
- ☐ **Cleaned Chorionic Villi** (5-15mg, back up culture required)

TEST REQUESTED

*For Hemoglobinopathy testing, see **Hemoglobinopathy Genetic Testing** Requisition.*
** Testing is not offered to individuals with elevated ferritin levels as the sole indication, or to asymptomatic minors [1,2]*

- ☐ Metachromatic Leukodystrophy *(ARSA)*
- ☐ Smith-Lemli-Opitz Syndrome *(DHCR7)*
- ☐ Medium Chain Acyl-Coenzyme Deficiency *(ACADM)*
- ☐ Very Long Chain Acyl-Coenzyme Deficiency *(ACADVL)*
- ☐ Gamma Polymerase Deficiency *(POLG)*
- ☐ Galactosemia *(GALT)*
- ☐ Hyperferritin Cataract Syndrome *(FTL)*
- ☐ Thiopurine S-Methyltransferase *(TMPT)*
- ☐ Bank DNA (for HHS/St. Joseph patients only)
- ☐ Prothrombin Gene Mutation/Factor V Leiden Genetic Test Panel
- ☐ Quebec Platelet Disorder *(PLAU)*
- ☐ Hemochromatosis *(HFE)* – select from criteria below*:
  - [ ] Fasting transferrin saturation >45%
  - [ ] Family history of C282Y homozygosity
  - [ ] Family history of C282Y/H63D compound heterozygosity
  - * **Documentation/reports required**; this can be emailed to moleculargenetics@hhsc.ca or attached to the requisition
- ☐ Other (contact lab first): _____

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): _____

References: [1] https://www.choosingwisely.org/societies/american-college-of-medical-genetics-and-genomics/, [2] https://www.choosingwiselycanada.org/hepatology/
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