Molecular Diagnostic Genetics Requisition

McMaster University Medical Centre
Molecular Genetics Laboratory, Room 2N22
1200 Main Street West, Hamilton, ON L8N 3Z5

Telephone: 905-521-2100 ex.76944
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Email: moleculargenetics@hhsc.ca

***Patient Last Name:** ***First Name:**

***DOB (DD/MM/YY)**

***SEX** ❑M ❑F ❑Other ______________________

***Health Card No:**

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

Test Requested:

Please see the HRLMP Laboratory Test Information Guide for complete sample requirements and information **https://www.ltig.hrlmp.ca/**

❑Hemoglobinopathy
Ethnicity:_______________________________
- ❑Thalassemia
- ❑Hemoglobin Variant
- ❑Sickle Cell Disease

***CBC, Hemoglobin electrophoresis, and ferritin results are required for processing samples.**

❑Hemochromatosis (*HFE*)
*Serum ferritin:_________________µg/L
*Transferrin saturation:___________%

❑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*)
❑Hyperferritinaemia Cataract Syndrome (*FTL*)
❑Bank DNA
❑Other (Enquire) ______________________

Expedited Cases are limited to: Prenatal Diagnosis, Newborn Screen Positive, or Patient/Partner Pregnant.

Specimen Information:

Transport at room temperature to the above address
Date sample taken/location: (DD/MM/YY)____________
❑Peripheral Blood in EDTA – 5ml
❑DNA, minimum 6 micrograms Source:____________
❑Amniotic Fluid, 10-15ml, back-up culture required
❑Cleaned Chorionic Villi, 5-15mg, back-up culture required
❑Cultured cells, confluent, 1xT25 flask, back-up culture required

Clinical Indications:

❑Symptoms of indicated disease
❑Carrier status
❑Newborn Screen Positive
❑Prenatal Diagnosis (provide information below)

Pregnancy Information
LMP (DD/MM/YY):_____________________
Procedure/Date (DD/MM/YY):_____________

❑Family history (Please provide details below)
❑Index case OR
Index Case Name: ________________________
DOB (DD/MM/YY): ________________________
Relationship: ______________________________

PROVIDE A SEPARATE PEDIGREE

❑Other___________________________________

Report to:

*Ordering Physician:
*Address:

*Phone:
*Fax:

*Authorized Signature:________________________________

Additional Copy to:

Physician:

Address:

Report will not be sent without complete information!

Lab Use Only: