Molecular Cytogenetics Constitutional Studies Requisition

Royal Columbian Hospital
Molecular Cytogenetics Laboratory Rm. B180
330 East Columbia Street, New Westminster, BC, V3L 3W7
Tel: (604) 520-4484 Fax: (604) 520-4149

Laboratory Use Only
Accessioning Number
Received Date

Patient Information

Last Name	First Name
Date of Birth (DD/MM/YY)	PHN
Gender: M ☐ F ☐	Patient Telephone #
Patient Address	

Physician Information

Ordering Physician (Name and Billing #)

Additional Reports to: (Name and Billing #)

Medical Genetics #:_____

Note: All Non-Canadian Residents must submit a signed and witnessed FHA waiver form. Please attach waiver to the lab requisition.

Further Collection and waiver from: Molecular Cytogenetics Specimen Collection and Submission

Outpatient blood collection: Book an appointment at Fraserhealth.ca through Laboratory Services or call 1-888-442-5227 or at Lifelabs.com *Note:* No pre-collection instructions required.

Clinical History

Known/Relevant Clinical Diagnosis:

Previous Cytogenetic Analysis: ☐ Yes ☐ No Cytogenetic Accession # _____

Relevant Family History and Consanguinity:

Peripheral Blood

1 x 3 mL Sodium Heparin **and** 2 x 3 mL EDTA
Newborn Infants (< 1 month): minimum 1 mL Sodium Heparin and 1 mL EDTA (Refer to Accessioning Manual - AM0725C1)

Test Requested

Indication: Please check all that apply

☐ **Karyotype**

- ☐ Trisomy 21
- ☐ Trisomy 18
- ☐ Trisomy 13
- ☐ Turner Syndrome
- ☐ Klinefelter Syndrome
- ☐ Ambiguous Genitalia
- ☐ Oligo / Azoospermia
- ☐ Premature Ovarian Failure
- ☐ 1º or ☐ 2º Amenorrhea
- ☐ Recurrent Pregnancy Loss (RPL)
- ☐ Infertility
- ☐ Patient or Partner is currently pregnant LMP:_____

Partner Name:_____
PHN:_____

☐ **Molecular Testing** ☐ Fragile X Syndrome ☐ Other (specify):_____ 1 x 3 mL EDTA, sent to MGL at BCCWH

☐ **FISH**

- ☐ Suspected Syndrome (specify): _____
- ☐ Known Familial Microdeletion / Microduplication Syndrome (specify):_____

☐ **Microarray**

Behavioural / Psychiatric
- ☐ Autism/ASD
- ☐ ADHD
- ☐ Psychiatric Disorder (specify):
  - ☐ Bipolar ☐ Schizophrenia
  - ☐ Other:_____

Growth Parameters
- ☐ IUGR
- ☐ Failure to thrive
- ☐ Microcephaly ☐ Macrocephaly
- ☐ Macrosomia (>95%ile)
- ☐ Short stature (<5%ile)
- ☐ Other:_____

Genitourinary
- ☐ Ambiguous Genitalia
- ☐ Hypospadias
- ☐ Undescended testes
- ☐ Other:_____

Developmental / Cognitive
- ☐ Global developmental delay
- ☐ Fine motor delay
- ☐ Gross motor delay
- ☐ Speech / language delay
- ☐ Learning disability
- ☐ Intellectual disability
- ☐ Other:_____

Craniofacial
- ☐ Dysmorphic facial features
- ☐ Hypotelorism
- ☐ Hypertelorism
- ☐ Deafness
- ☐ Low set / abnormal ears
- ☐ Cleft lip / Cleft palate
- ☐ Coloboma of eye
- ☐ Craniosynostosis
- ☐ Other:_____

Neurological
- ☐ Seizures ☐ Ataxia
- ☐ Hypotonia ☐ Dystonia
- ☐ Spasticity ☐ Chorea
- ☐ Neural tube defect
- ☐ Structural brain abnormality
- ☐ Other:_____

Musculoskeletal
- ☐ Contratures
- ☐ Clubfoot
- ☐ Diaphragmatic hernia
- ☐ Limb anomaly
- ☐ Polydactyly ☐ Syndactyly
- ☐ Vertebral anomaly
- ☐ Other:_____

Gastrointestinal
- ☐ Gastroschisis
- ☐ Anal atresia
- ☐ Omphalocele
- ☐ Pyloric stenosis
- ☐ Tracheoesophageal fistula
- ☐ Other:_____

Cardiac
- ☐ ASD ☐ VSD
- ☐ AV canal defect
- ☐ Coarctation of aorta
- ☐ Hypoplastic left heart
- ☐ Tetralogy of Fallot
- ☐ Other:_____

Other:_____

☐ **Microarray Follow-up**

Please provide previous Microarray Accession #:_____

☐ Proband ☐ Family Member Relationship to proband:_____

Ordering Physician Signature (Required) Date (DD/MM/YYY)