Saskatchewan Health Authority

Patient Label

NAME: _____

HSN: _____

D.O.B.: _____

❑ RUH ❑ SCH ❑ SPH ❑ Other _____

DEPARTMENT OF PATHOLOGY & LABORATORY MEDICINE

CYTOGENETICS TESTING REQUISITION

Genomics Laboratory | Room 5627, 5th Floor, 1955 Building, RUH | Phone: 306-655-1706 | Fax: 306-655-6462

ALL sections must be completed to avoid delays in processing.

PATIENT INFORMATION

Patient name: _____ Gender: ❑ Male ❑ Female
(Surname) (Given name)

Address: _____ Phone (Home/Work): _____

HSN: _____ RUH #: _____ Date of birth (dd/mm/yy): _____

❑ Outpatient ❑ Inpatient – Ward _____ Kindred #: _____

PHYSICIAN INFORMATION

Ordering physician: _____ Phone: _____ Fax: _____

Copy to: _____ Phone: _____ Fax: _____

Copy to: _____ Phone: _____ Fax: _____

TEST REQUESTED

❑ Chromosome analysis ❑ Rapid aneuploidy detection (RAD) ❑ Tissue culture: ❑ Frozen storage

❑ FISH (please specify probe): _____ ❑ Shipment

SPECIMEN COLLECTION INFORMATION

Collection date (dd/mm/yy): _____ Time: _____ Initials: _____

SPECIMEN INFORMATION AND CLINICAL INDICATION

Amniotic Fluid
15-20 mL in sterile tubes, e.g. Corning or Falcon

Gestational age: _____
Twin pregnancy: ❑ Twin A ❑ Twin B

CLINICAL INDICATION
- ❑ Positive MSS (include report)
- ❑ Maternal age greater than 40
- ❑ Anomalies (please specify in 'Other' field)
- ❑ Fetal growth restriction
- ❑ Previous pregnancy with chromosomal abnormality (please specify in 'Other' field)
- ❑ Family history of chromosomal abnormality (please specify in 'Other' field)
- ❑ Family history of genetic disease (must be referred through Medical Genetics)

❑ **Blood / ❑ Cord blood**
- 2-7 mL in green top, **SODIUM HEPARIN** tube;
- 1-3 mL for neonates

CLINICAL INDICATION
- ❑ Aneuploidy (please specify in 'Other' field)
- ❑ Congenital anomalies
- ❑ Ambiguous genitalia
- ❑ Dysmorphic features
- ❑ Failure to thrive
- ❑ Developmental delay
- ❑ Sex chromosome abnormality
- ❑ Short stature
- ❑ Excessive growth
- ❑ Infertility
- ❑ Multiple miscarriages (greater than/equal to 3)
- ❑ Family history of chromosomal abnormality

❑ **Bone marrow / ❑ Oncology blood**
1-3 mL BM or 2-7 blood in a green top, **SODIUM HEPARIN** tube or sterile tube with transport media

- ❑ New diagnosis
- ❑ Follow up ❑ Relapse
- ❑ Post treatment
- ❑ Post transplant

CLINICAL INDICATION
- ❑ AML ❑ CLL
- ❑ APL ❑ MM/PCD
- ❑ ALL ❑ Lymphoma
- ❑ MDS ❑ MPD
- ❑ CML ❑ Potential donor

Solid Tissue
0.5 x 0.5 cm in a sterile container with **STERILE SALINE/MEDIA**

NOTE: Send POC specimens to Anatomic Pathology at SCH for fetal tissue identification first

Source (e.g. skin, POC):
_____

CLINICAL INDICATION
- ❑ Multiple miscarriages (greater than/equal to 3)
- ❑ Fetal anomaly/malformation
- ❑ Culture for biochemical or DNA testing

❑ Other indication/information: _____
_____
_____

Ordering physician signature (required)**:** _____

FOR LABORATORY USE ONLY

Received date (dd/mm/yyyy or stamp): _____ Lab number: _____ Initials: _____

Specimen details [e.g. container(s); volume; quality]: _____