Saskatchewan Health Authority

Genomics Laboratory
Royal University Hospital
Room 5617, 5th Floor, 1955 Building
103 Hospital Drive, Saskatoon, SK S7N 0W8
Phone: 306-655-1706 Fax: 306-655-6462
Email: cytogenetics@saskatoonhealthregion.ca

❑ RUH ❑ SCH ❑ SPH ❑ Other _____

DEPARTMENT OF PATHOLOGY AND LABORATORY MEDICINE

GENERAL REQUISITION – CYTOGENETICS AND MOLECULAR GENETICS TESTING

PATIENT INFORMATION		**PHYSICIAN INFORMATION**	
Patient Name and Address [Print clearly]	Patient HSN	Provider [Last Name, First Name, and Middle Initial]	Provider MSB #
PATIENT LABEL	Date of Birth [DD/MM/YYYY]	Return Address [Provider/Clinic/Hospital] Ordering Provider Fax #	
Kindred #	❑ Male ❑ Female	If an additional copy is required: Provider _____ Fax # _____ Last Name First Name Provider _____ Fax # _____ Last Name First Name Provider _____ Fax # _____ Last Name First Name	
❑ Outpatient ❑ Inpatient – Ward _____			
Collection date [DD/MM/YYYY]	Collection Site		

SPECIMEN REQUIREMENTS

Cytogenetics *(All collections in Sodium Heparin tubes with the exception of amniotic fluid and tissue)*

- ❑ Amniotic Fluid: 15-35 mL in sterile tubes
- ❑ Peripheral Blood: 2-7 mL*
- ❑ Cord Blood: 2-5 mL*
- ❑ Tissue: 5 x 5 mm minimum in sterile media (*source*) _____**
- ❑ Bone Marrow: 1-3 mL
- ❑ Oncology Blood: 2-7 mL
- ❑ Other: _____

Molecular Genetics *(All collections in EDTA tubes with the exception of tissue)*

- ❑ Peripheral Blood: 2-7 mL*
- ❑ Cord Blood: 2-5 mL*
- ❑ Tissue: 5 x 5 mm minimum fresh or frozen (*source*) _____**
- ❑ Banked DNA #: _____
- ❑ Other: _____

***For neonates, 1-3 mL of blood is acceptable**

****All POC specimens must be sent to Anatomic Pathology at SCH for fetal tissue identification prior to proceeding with genomic testing**

TEST PRIORITY

❑ Routine ❑ STAT – Reason _____

TEST REQUESTED

Cytogenetics

- ❑ Karyotype ❑ FISH (Condition): _____
- ❑ FISH for Microarray Follow Up – Array Lab No.: _____
- ❑ Tissue Culture: ❑ Freeze ❑ Shipment

***Microarray must be ordered using Microarray Requisition, NOT THIS FORM**

Molecular Genetics

- ❑ Rapid Aneuploidy Detection (RAD)
- ❑ Maternal Cell Contamination (MCC)
- ❑ qPCR for Microarray follow up – Array Lab No.: _____
- ❑ DNA Extraction and Banking

For Laboratory Use Only	Lab Number	Date Received [DD/MM/YYYY]	Initials

Specimen Comments [e.g., collection tubes, volume, quality]:

THIS IS A TWO-PAGE FORM. COMPLETE IN FULL TO AVOID DELAY IN TESTING.

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CLINICAL INDICATIONS (Please complete to ensure accurate and timely reporting)

Prenatal:	**Postnatal:**	**Oncology:**
❑ **Gestational age:** _____	❑ Aneuploidy (specify below)	❑ New diagnosis
❑ Twin pregnancy:	❑ Congenital anomalies	❑ Follow up
❑ Twin A	❑ Ambiguous genitalia	❑ Relapse
❑ Twin B	❑ Dysmorphic features	❑ Post-treatment
❑ Positive MSS (include report)	❑ Failure to thrive	❑ Post-transplant
❑ Maternal age greater than 40	❑ Developmental delay	❑ Potential donor
❑ Ultrasound anomalies (specify below)	❑ Sex chromosome abnormality	❑ AML
❑ Fetal growth restriction	❑ Short stature	❑ APL
❑ Previous pregnancy with chromosomal abnormality (specify below)	❑ Excessive growth	❑ ALL
❑ Family history of chromosome abnormality (specify below)	❑ Infertility	❑ MDS
❑ Family history of genetic disease (must be referred through Medical Genetics)	❑ Multiple miscarriages (greater than/ equal to 3)	❑ CML
❑ Other: _____	❑ Family history of chromosome abnormality	❑ CLL
	❑ Other: _____	❑ MM/PCD
		❑ Lymphoma
		❑ MPD

FAMILY HISTORY, PEDIGREE, AND ADDITIONAL INFORMATION

PRE-TEST CONSENT FOR GENETIC TESTING

The following points are to be discussed with the patient/guardian by the health-care provider prior to order genetic testing:

1. Specimen analysis will be limited to related clinical condition(s) as indicated above.
2. For genetic testing, patient sample(s) will be collected in order to extract DNA or otherwise process for genetic testing and any remaining specimen will be stored by the Genomics Lab. If there is enough sample left when testing is complete, it may be used anonymously (identifying information will be removed) for research and quality assurance purposes.
3. Correlation with clinical information may be required for accurate interpretation. Correct interpretation of results can also depend on accurate family relationships being provided.
4. The genetic test(s) may not detect all genetic abnormalities associated with this condition. The accuracy of the genetic test requested as well as the potential benefits and limitations have been reviewed with the patient.
5. DNA analysis may reveal a change in a gene that has unknown clinical significance. It may also reveal unexpected information about family relationships (e.g., non-paternity).
6. The results of this testing are entirely confidential but may be used without identifying information for the interpretation of genetic testing for family members.
7. Genetic test results can be complex and may have important implications. When the genetic testing is complete, results will be discussed with the patient by the health-care provider.
8. Genetic counseling is available if requested. This will require a referral to the Medical Genetics clinic.

I have reviewed the points above, as well as the benefits and limitations of genetic testing with the patient/guardian.
I have answered all the patient's/guardian's questions and have obtained verbal consent to order the indicated testing(s).

Ordering Physician: _____ _____
Printed Name Signature (Required)

Date: _____

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