CYTOGENETICS LABORATORY
DEPARTMENT OF PATHOLOGY AND LABORATORY MEDICINE
ROYAL UNIVERSITY HOSPITAL
103 HOSPITAL DRIVE
ROOM 5627, 5th FLOOR, 1955 BUILDING
SASKATOON, SK S7N 0W8
PHONE: 306-655-1706
FAX: 306-655-6462

Addressograph or Label

Use patient label or enter information below

ALL sections must be completed to avoid delays in processing.

PATIENT INFORMATION

Patient Name: _____ Gender: ☐ M ☐ F
(SURNAME) (GIVEN NAME)

Address: _____ Phone (Home/Work): _____

PHN/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

☐ Tissue Culture: ☐ Frozen storage ☐ Shipment

☐ FISH (please specify probe): _____

SPECIMEN INFORMATION

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

SPECIMEN TYPE AND CLINICAL INDICATION

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

Gestational Age:

_____
Twin Pregnancy: ☐ Twin A ☐ Twin B

CLINICAL INDICATION
☐ Positive MSS (include report)
☐ Anomalies (please specify in "Other" field below)
☐ Fetal growth restriction
☐ Maternal age >40
☐ Previous pregnancy with chromosomal abnormality (please specify in "Other" field")
☐ Family history of chromosome abnormality (please specify in "Other" field)
☐ Family history of genetic disease (must be referred through Medical Genetics)

Blood
- 2-7 mL in a green top, **SODIUM HEPARIN** tube;
- 1-3 mL for neonates

CLINICAL INDICATION
☐ Aneuploidy (please specify in "Other" field below)
☐ Congenital anomalies
☐ Ambiguous genitalia
☐ Dysmorphic features
☐ Failure to thrive
☐ Developmental Delay
☐ Sex chromosome abnormality
☐ Short stature
☐ Excessive growth
☐ Infertility
☐ Multiple miscarriages (≥3)
☐ Family history of chromosome abnormality

☐ Bone Marrow /☐ Oncology Blood
1-3 mL BM or 2-7 mL 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**

Source (e.g. skin, POC):

_____

CLINICAL INDICATION
☐ Multiple miscarriages (≥3)
☐ Fetal anomaly/malformation
☐ Culture for biochemical or DNA Testing

☐ Other Indication/Information: _____

_____

Ordering Physician Signature:_____ **(REQUIRED)**

FOR LABORATORY USE ONLY:

Received Date: _____ Lab Number: _____ Initials: _____
(dd/MON/yyyy) or stamp

Specimen Details: _____
(e.g. container(s); volume; quality)