Saskatchewan Health Authority

Roy Romanow Provincial Laboratory

Molecular Diagnostics – Molecular Genetics Requisition

RRPL Use Only

Patient Name & Address (Print Clearly)

K#

RRPL Use Only

Patient HSN

Date of Birth D / M / Y

☐ **Male** ☐ **Female**

Ethnicity

Collection Date D / M / Y

Collection Time H / M

Provider (Include First Name and Middle Initial)

Provider MSB #

Return Address (Provider/Clinic/Hospital)

Ordering Provider Fax #:

If an Additional Copy is Required:

Provider _____ (Last Name First Name Initial) Fax # _____

Address _____

City/Prov. _____ Postal Code _____

Specimen EDTA whole blood:

Minimum: 2 x 4 ml EDTA tubes, lavender/purple top (min 8 ml)

Infant/Newborn 0.5-3 ml EDTA

Ship at Room Temperature.

Can be kept overnight at 4°C.

Reason for Analysis:

- ☐ Diagnostic testing
- ☐ DNA Banking
- ☐ Pre-symptomatic testing*
- ☐ Testing for known variant*: _____

* Can only be ordered by a Genetic Counsellor or Medical Geneticist

Test Requested: **Physician signature required on page 2**

- ☐ Angelman syndrome
- ☐ Beckwith-Wiedemann syndrome
- ☐ CFTR-related conditions
  - ☐ classical CF ☐ CBAVD ☐ other _____
- ☐ Congenital Adrenal Hyperplasia
- ☐ FMR1-related disorders
  - ☐ Fragile X syndrome ☐ FXTAS ☐ POF
- ☐ Hemoglobinopathies
  (please attach CBC, Hb electrophoresis & ferritin results)
- ☐ Prader-Willi syndrome
- ☐ Rett syndrome
- ☐ Russell-Silver syndrome
- ☐ Y-microdeletion
- ☐ Other Genetic Test (Compete the greyed boxes on page 2)

Condition\Test: _____

- ☐ Spinal muscular atrophy (*SMN1/2*)
- ☐ CADASIL
- ☐ Charcot-Marie-Tooth Disease
  - ☐ Type 1A ☐ Type 1B ☐ Type X
- ☐ Hereditary neuropathy with liability to pressure palsy
- ☐ Huntington disease
- ☐ Myotonic dystrophy type 1
- ☐ Myotonic dystrophy type 2
- ☐ Friedreich's ataxia
- ☐ Muscular dystrophy
  - ☐ DMD/BMD ☐ LGMD ☐ OPMD
- ☐ Spinal & bulbar muscular atrophy
- ☐ Spinocerebellar ataxia (SCA)
  - ☐ General screen ☐ SCA 17 ☐ Specific _____
- ☐ Hemochromatosis (please complete required information)

Serum ferritin: _____ % Transferrin saturation: _____

If this test will impact an ongoing pregnancy, please fax an urgent referral to the division of medical genetics: 306-655-1736

Is this request urgent (i.e. results needed for treatment decisions within 6-8 weeks?)

☐ No ☐ Yes _____ (Reason for Urgency)

Questions: contact (306) 655-6450 or GRC@saskhealthauthority.ca

Clinical and Family History Information:

If appropriate consent has been obtained, please provide relevant clinical information, including names of relatives tested previously & attach laboratory reports.

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Complete greyed portion only if selecting "Other Genetic Test" on page 1

If testing is authorized, a requisition form for an external lab will be forwarded to the ordering physician.

Rationale for testing

What is the therapeutic impact of this testing **for the patient?**

- ☐ New Management
- ☐ Adjust to more specific management
- ☐ Cease or reduce investigation for diagnosis
- ☐ No change in management

Please provide specific details regarding your selection (**required**):

What is the therapeutic impact of this testing **for at risk relatives?** ☐ **n/a**

- ☐ Preventive management
- ☐ Specific screening recommendations or risk reduction strategies
- ☐ Reproductive decision-making
- ☐ Identify individuals at risk – little or no change in management

Specify who will be impacted by testing and in what way (**required**):

What is the clinical diagnosis?

Please send supporting information (consult notes, reports, labs, etc.) by fax to (306)791-4630 or secure email – GRC@saskhealthauthority.ca

Are other tests **currently** underway (i.e. chromosome analysis, Fragile X)?

☐ No ☐ Yes (specify)

Have other genetic tests ever been run?

☐ No ☐ Yes (specify)

Pre-test Counselling and Healthcare Provider Consent

The following points are to be discussed with the patient and/or guardian(s) prior to ordering molecular testing.

1. The results of the genetic test may:
   - Confirm that the individual tested has the condition specified above (i.e., diagnostic test) or is at-risk of developing this condition (i.e., predictive test);
   - Indicate whether or not the individual tested or a family member is a carrier of this condition;
   - Reveal that another family member has or is at-risk for developing this condition;
   - Reveal that people are not blood related (i.e., non-paternity, adoption).

2. This DNA test is specific only for the condition named above. It may not detect all possible genetic changes related to this condition and it will not detect changes in other genes unrelated to this condition.

3. The significance of the different types of results (positive, negative, variants of unknown significance).

4. Although genetic testing usually gives precise information, several rare sources of error are possible. These include, but are not limited to, clinical misdiagnosis of the condition, sample misidentification, sample contamination and inaccurate information regarding family relationships.

5. DNA testing may cause emotional stress, strain on relationships and may result in discrimination (immigration or work-related). All test results are kept in a secure medical record, only to be accessed by healthcare providers involved in their care. For more information about your legal rights under the Genetic Non-discrimination Act (GNA), formerly Bill S-2018, please refer to www.parl.ca for full text of the law or www.cagc-accg.ca for a GNA fact sheet.

6. The patient consents to the following persons having access to their results should they not be able to receive themselves:

   _____

7. Minimal risks involved in drawing a blood sample include pain at the blood drawing site, bleeding, bruising and infection.

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 test(s).

Physician / Genetic Counsellor: _____ **Date**: _____

(Signature required)

I ☐ consent / ☐ do not consent for my /my child's DNA sample and test results to be used to help other family members.

I ☐ consent / ☐ do not consent for my / my child' DNA sample to be kept in long-term storage by the Roy Romanow Provincial Laboratory.

I ☐ consent / ☐ do not consent for my / my child's DNA sample to be anonymized (name removed) and used to help the Roy Romanow Provincial Laboratory validate genetic tests that might help other patients.

If at any time in the future you no longer consent to having this DNA stored, you may contact Molecular Genetics Lab Services at the Roy Romanow Provincial Lab at (306) 787-3192 and it will be destroyed with a signed request.
Further information about RRPL DNA banking policies is accessible at RRPL-TestViewer.eHealthSask.ca or by contacting the lab.

Name of Signatory: _____ Relationship to Patient: _____

Signature: _____ Date: _____

*Note that without a patient signature, it will be assumed that consent has not been provided for the 3 above options and DNA will be discarded after 1 year.