

MOLECULAR GENETICS LABORATORY Requisition

BC Children's Hospital & BC Women's Hospital

Facility Code L1050

2J40 - 4500 Oak Street
Vancouver, BC V6H 3N1

www.genebc.ca

Phone (604) 875-2852

Fax (604) 875-2707

moleculargenetics@cw.bc.ca

**CW SUNQUEST
LABEL
ONLY**

**MOLECULAR LAB
LABEL
ONLY**

Ordering Physician			Patient Information		
Last Name	First Name	Billing #	Last Name	First and Middle Names	
Address			Gender	Date of Birth (DD/MMM/YY)	
			<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> UNK		
Phone	Fax		Personal Health Number (PHN)	Referring Hospital ID	Referring Clinic ID
Contact Person		Phone	Address		
Copy Physician		Billing #			Patient Phone Number
Copy Physician		Billing #	Eligible for BC Medical Services Plan (MSP) billing?		
			<input type="checkbox"/> Yes <input type="checkbox"/> No → billing form must be completed; see website .		

Sample Type		Collection Details		COLLECTION LAB LABEL ONLY
See website or eLab Handbook for minimum & test specific volumes For all fetal samples, use the Prenatal Genetics Requisition		Date Collected (DD/MMM/YY)	Collector's Initials	
<input type="checkbox"/> EDTA Blood - 4 mL; store/ship at room temperature. <input type="checkbox"/> Bone Marrow <input type="checkbox"/> DNA from: (tissue type) _____ Sample ID: _____ DNA is not accepted for MLPA <input type="checkbox"/> Other (specify): _____ Path #: _____		Time Collected (HH:MM)	Request #	

Reason For Testing REQUIRED (CHECK ONE ONLY)	Test(s) Requested <small>(See website for test details, guidelines and lab policy)</small>		MGL USE ONLY
<input type="checkbox"/> Confirmation of Diagnosis. Has symptoms or signs. <input type="checkbox"/> Presymptomatic Testing Risk of developing symptoms. Requires molecular diagnosis in family (provide history/mutation(s) below). Genetic counselling may be required. <input type="checkbox"/> Carrier Testing – see policy re: minors	<input type="checkbox"/> Achondroplasia <input type="checkbox"/> Alloimmune Thrombocytopenia (Hpa-1) +▲ <input type="checkbox"/> Angelman Syndrome <input type="checkbox"/> Ashkenazi Carrier Screening ◀◆◆ <input type="checkbox"/> Brugada Syndrome ◆ <input type="checkbox"/> CADASIL <input type="checkbox"/> Charcot-Marie-Tooth Type 1A <input type="checkbox"/> Chimerism ● <input type="checkbox"/> Cystic Fibrosis ■ Disorders of Sex Development ◆ <input type="checkbox"/> Androgen Insensitivity Syndrome <input type="checkbox"/> Steroid 5-Alpha-Reductase Deficiency <input type="checkbox"/> Dystonia, early onset primary (DYT1) <input type="checkbox"/> Dystrophinopathies (DMD, BMD) FMR1-Related Disorders <input type="checkbox"/> Fragile X Syndrome <input type="checkbox"/> Premature Ovarian Insufficiency <input type="checkbox"/> FXTAS <input type="checkbox"/> Friedreich Ataxia <input type="checkbox"/> Glucose Transporter Type 1 Deficiency Syndrome ◀◆	<input type="checkbox"/> Muenke Syndrome <input type="checkbox"/> Myotonic Dystrophy Type 1 <input type="checkbox"/> Oculopharyngeal Muscular Dystrophy Periodic Fever Syndromes <input type="checkbox"/> Familial Mediterranean Fever <input type="checkbox"/> Hyper IgD Syndrome ◆ <input type="checkbox"/> TRAPS ◆ <input type="checkbox"/> Prader-Willi Syndrome <input type="checkbox"/> Sensorineural Hearing Loss (GJB2/6) <input type="checkbox"/> Spinal Muscular Atrophy <input type="checkbox"/> Spinal and Bulbar Muscular Atrophy <input type="checkbox"/> Spinocerebellar Ataxia Panel (SCA1,2,3,6,7) <input type="checkbox"/> Thanatophoric Dysplasia <input type="checkbox"/> Transthyretin Amyloidosis Uniparental Disomy ▲ <input type="checkbox"/> Ch6 <input type="checkbox"/> Ch7 <input type="checkbox"/> Ch14 <input type="checkbox"/> Ch15 <input type="checkbox"/> X-linked Ichthyosis (STS Deficiency) <input type="checkbox"/> Zygosity ●◆ <input type="checkbox"/> Other: _____	
Relevant Clinical/Family History	Also provide Name, DoB, PHN & relationship of any individual(s) relevant to interpretation of requested test(s). <input type="checkbox"/> Alpha Thalassemia <input type="checkbox"/> Beta Thalassemia <input type="checkbox"/> Hemoglobin S,E,C Hemolytic Disease of the Newborn +▲ <input type="checkbox"/> RhD <input type="checkbox"/> RhC <input type="checkbox"/> RhE <input type="checkbox"/> Kell <input type="checkbox"/> Hereditary Neuropathy with Liability to Pressure Palsies <input type="checkbox"/> Huntington Disease <input type="checkbox"/> Hypochondroplasia (includes Achondroplasia) <input type="checkbox"/> Hyperkalemic periodic paralysis <input type="checkbox"/> Hypokalemic periodic paralysis		
Ordering Physician Signature REQUIRED _____		Date _____	

◀ **Supplemental Info Sheet REQUIRED**
 + **Additional information REQUIRED**
 ◆ **Guideline compliance REQUIRED**
 ● **BC MSP or Yukon Health Services only**
 ▲ **Parental samples required**
 ■ **Ethnicity required for interpretation**