MOLECULAR GENETICS LABORATORY Requisition

BC Children's Hospital & BC Women's Hospital
Facility Code L1050
2J40 - 4500 Oak Street
Vancouver, BC V6H 3N1
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Phone (604) 875-2852
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moleculargenetics@cw.bc.ca

CW SUNQUEST LABEL ONLY

MOLECULAR LAB LABEL ONLY

Ordering Physician

Last Name	First Name	Billing #

Address

Phone | Fax

Contact Person | Phone

Copy Physician | Billing #

Copy Physician | Billing #

Patient Information

Last Name	First and Middle Names

Gender ☐ M ☐ F ☐ UNK

Date of Birth (DD/MMM/YY)

Personal Health Number (PHN) | Referring Hospital ID | Referring Clinic ID

Address

Patient Phone Number

Eligible for BC Medical Services Plan (MSP) billing?
☐ Yes ☐ No → billing form must be completed; see website.

Sample Type

See website or eLab Handbook for minimum & test specific volumes
For all fetal samples, use the Prenatal Genetics Requisition

- ☐ EDTA Blood - *4 mL; store/ship at room temperature.*
- ☐ Bone Marrow
- ☐ DNA from: *(tissue type)*_____ Sample ID: _____
  DNA is not accepted for MLPA
- ☐ Other (specify): _____ Path #: _____

Collection Details

Date Collected (DD/MMM/YY)	Collector's Initials
Time Collected (HH:MM)	Request #

COLLECTION LAB LABEL ONLY

Reason For Testing

REQUIRED (CHECK ONE ONLY)

- ☐ Confirmation of Diagnosis.
  Has symptoms or signs.
- ☐ Presymptomatic Testing
  Risk of developing symptoms.
  Requires molecular diagnosis in family (provide history/mutation(s) below).
  Genetic counselling may be required.
- ☐ Carrier Testing – see policy re: minors

Patient Ethnicity

Partner:

Partner PHN:

Will this testing **alter the management** of ongoing pregnancy? ☐ Yes ☐ No

If yes, provide the following:

EDD (DD/MMM/YY):

Name & Relationship (if other than above):

PHN:

Relevant Clinical/Family History

Also provide Name, DoB, PHN & relationship of any individual(s) relevant to interpretation of requested test(s).

Test(s) Requested

(See website for test details, guidelines and lab policy)

- ☐ Achondroplasia
- ☐ Alloimmune Thrombocytopenia (Hpa-1) + ▲
- ☐ Angelman Syndrome
- ☐ Ashkenazi Carrier Screening ◀ ■ ◆
- ☐ Brugada Syndrome ◆
- ☐ CADASIL
- ☐ Charcot-Marie-Tooth Type 1A
- ☐ Chimerism ●
- ☐ Cystic Fibrosis ■

Disorders of Sex Development ◆
- ☐ Androgen Insensitivity Syndrome
- ☐ Steroid 5-Alpha-Reductase Deficiency

- ☐ Dystonia, early onset primary (DYT1)
- ☐ Dystrophinopathies (DMD, BMD)

FMR1-Related Disorders
- ☐ Fragile X Syndrome
- ☐ Premature Ovarian Insufficiency
- ☐ FXTAS

- ☐ Friedreich Ataxia
- ☐ Glucose Transporter Type 1 Deficiency Syndrome ◀ ◆

Hemoglobin Disorders + ◆ ■
- ☐ Alpha Thalassemia
- ☐ Beta Thalassemia
- ☐ Hemoglobin S,E,C

Hemolytic Disease of the Newborn + ▲
- ☐ RhD ☐ RhC ☐ RhE ☐ Kell

- ☐ Hereditary Neuropathy with Liability to Pressure Palsies
- ☐ Huntington Disease
- ☐ Hypochondroplasia (includes Achondroplasia)
- ☐ Hyperkalemic periodic paralysis
- ☐ Hypokalemic periodic paralysis
- ☐ Muenke Syndrome
- ☐ Myotonic Dystrophy Type 1
- ☐ Oculopharyngeal Muscular Dystrophy

Periodic Fever Syndromes
- ☐ Familial Mediterranean Fever
- ☐ Hyper IgD Syndrome ◆
- ☐ TRAPS ◆

- ☐ Prader-Willi Syndrome
- ☐ Sensorineural Hearing Loss (GJB2/6)
- ☐ Spinal Muscular Atrophy
- ☐ Spinal and Bulbar Muscular Atrophy
- ☐ Spinocerebellar Ataxia Panel (SCA1,2,3,6,7)
- ☐ Thanatophoric Dysplasia
- ☐ Transthyretin Amyloidosis

Uniparental Disomy ▲
☐ Ch6 ☐ Ch7 ☐ Ch14 ☐ Ch15

- ☐ X-linked Ichthyosis (STS Deficiency)
- ☐ Zygosity ● ◆
- ☐ Other: _____

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

_____ Ordering Physician Signature REQUIRED

_____ Date

MGL USE ONLY

SAVE & EMAIL FORM

PRINT FORM

CLEAR FORM