PRENATAL GENETICS LABORATORY REQUISITION

BC Children's Hospital and BC Women's Hospital Facility Code L1050
4500 Oak Street, Vancouver B.C. V6H 3N1
Cytogenetics Tel: 604-875-2304, Fax: 604-875-3601
Molecular Genetics Tel: 604-875-2852, Fax: 604-875-2707
www.genebc.ca

Patient Information

Last Name	First and Middle Names	
Gender: X Female	Date of Birth (DD/MMM/YY)	
Personal Health Number (PHN)	Referring Hospital ID	Referring Clinic ID
Address		
Patient Phone Number	Multiple Gestation – select only ONE: ☐ Fetus A ☐ Fetus B ☐ Fetus C	

Ordering Physician

Last Name	First Name	Billing #
Address		
Phone	Fax	
Contact Person / Genetic Counsellor	Phone	
Copy Physician		Billing #
Copy Physician		Billing #

GENETICS LABORATORY LABELS ONLY

Reproductive History	Procedure Date (DD/MMM/YY)	Current Gestational Age	☐ EDD by U/S ☐ LMP (DD/MMM/YY)
G: _____ T: _____ P: _____ A: _____ L: _____		_____ weeks _____ days	

Reason For Referral REQUIRED

Choose all that apply; analysis will not be performed unless appropriate history is provided.

- ☐ 40+ years
- ☐ 35 – 39 years, no prior screening, singleton, ≥ 21 wks gestation (at first prenatal visit)
- ☐ ≥35 years, no prior screening, multiple gestation

Age at projected birth: _____

- ☐ Positive maternal screen: ☐ IPS ☐ SIPS ☐ Quad ☐ NIPT ☐ Other: _____

Positive for: ☐ T21 ☐ T18 ☐ Other: _____ Risk: _____

- ☐ In vitro fertilization with intracytoplasmic sperm injection (IVF with ICSI)

Additional information must be provided for the following:

- ☐ Fetal ultrasound abnormality
- ☐ Fetus at risk of inherited disease
- ☐ Personal/family history of chromosome abnormality
- ☐ Follow up after CVS
- ☐ Culture for: ☐ Biochemical Genetics ☐ Possible future testing (please specify)
- ☐ Supernatant fluid to: ☐ Biochemical Genetics ☐ Clinical Biochemistry

Relevant clinical and family history:

Test(s) Requested

- ☐ QF-PCR Rapid Aneuploidy Detection (RAD)
- ☐ Chromosome microarray (CMA)
- ☐ Molecular test: _____
  Specify test & FAX req to MGL (2707) at time of scheduling
- ☐ Other: _____
  Specify (ex. Karyotype, FISH probe)

Sample Type *Use this requisition for prenatal samples ONLY*

- ☐ 25 mL Amniotic fluid
- ☐ 2 mL Fetal Blood (*Kleihauer required for cordocentesis)*
- ☐ 20 mg CVS
- ☐ Other: _____ Path #_____

Collection Details

Date Collected (DD/MMM/YY)	Time Collected (HH:MM)

Specify Site

_____ Ordering Physician Signature REQUIRED

_____ Date

Date Arrived: _____ Previous Studies: _____

GENETICS LABORATORY USE ONLY

Print Form

Save Form

Clear Form