

Molecular Genetics Laboratory

BC Children's Hospital & BC Women's Hospital
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 • Facility Code L1050

Request for Shipment

Out-of-Province/Out-of-Country Genetic Testing

To: Molecular Genetics Laboratory (MGL)**Fax:** 604-875-2707**Phone:** 604-875-2852

From:
Fax:
Date:
Pages:

COMPLETE FOR EACH SAMPLE & EACH REFERRAL LABORATORY

PRIORITY	SAMPLE TYPE	
<input type="checkbox"/> STAT (affects pregnancy management) EDD: _____ <small>DD/MMM/YY</small>	<input type="checkbox"/> BLOOD	MEDICAL GENETICS ONLY: CVS OR AMNIOCENTESIS: <input type="checkbox"/> DNA <input type="checkbox"/> Cultured <input type="checkbox"/> Uncultured* <small>*consultation required</small>
<input type="checkbox"/> ROUTINE	<input type="checkbox"/> TISSUE ; Surgical Path #: _____ <input type="checkbox"/> DNA* ; MGL Sample ID: _____ <small>*prior approval required, as per policy</small> Quantity: _____ ug OR _____ ug/ul & _____ ul	
SPECIAL INSTRUCTIONS: (quantity, # flasks, etc.) _____		

REQUESTOR INFORMATION		PATIENT INFORMATION	
Ordering Physician Last Name	Ordering Physician First Name	Last Name	First Name
Contact Person (if differs from Ordering Physician)		Personal Health Number	Date of Birth (DD/MMM/YY)
Contact Phone Number (if differs from above)		Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> UNK	Referring Clinic ID

REFERRAL LABORATORY & TEST INFORMATION	
Referral Laboratory	Disorder or Test Requested
Shipping Address:	

CHECKLIST: <input type="checkbox"/> BC's Agency for Pathology and Laboratory Medicine Agreement and Consent for Out of Province testing form <input type="checkbox"/> Referral Lab paperwork <input type="checkbox"/> Provide Funding Details:	MGL USE ONLY SHIPMENT LABEL CM_PW <input type="checkbox"/>
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