

LHSC BIOCHEMICAL GENETICS LABORATORY

Requisition for DNA Testing

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| <p><u>SEND TO:</u></p> <p><input type="checkbox"/> LHSC Biochemical Genetics Laboratory CPRI - Leonard Building, 2nd floor 600 Sanatorium Road London, Ontario. N6H 3W7 Ph: (519) 858-2774 x2211 Fax: (519) 858-1063</p> | <p>AUTHORIZED SIGNATURE IS REQUIRED TO PROCEED WITH TESTING</p> <p>Patient's Name _____</p> <p>Birthdate <u> </u> <u> </u> / <u> </u> <u> </u> / <u> </u> <u> </u></p> <p>Patient's Address: _____</p> |
| <p><u>FAMILY INFORMATION:</u></p> <p>Have samples from this family been sent to a DNA lab before? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, specify _____</p> <p><input type="checkbox"/> This individual is the index case <input type="checkbox"/> or name of index case in the family _____ D.O.B. <u> </u> <u> </u> / <u> </u> <u> </u> / <u> </u> <u> </u></p> <p>Relationship to this patient: _____</p> | <p>Health Card # _____</p> <p><u>PEDIGREE:</u></p> |
| <p><u>TEST REQUESTED:</u></p> <p><input type="checkbox"/> Adenosine deaminase deficiency (ADA) <input type="checkbox"/> Arginase deficiency (ARG1) <input type="checkbox"/> Biotinidase deficiency (BTD) <input type="checkbox"/> Chondrodysplasia punctata 1 (ARSE) <input type="checkbox"/> Cystinosis (CTNS) <input type="checkbox"/> Glutaric acidemia, type I (GCDH) <input type="checkbox"/> Glycogen storage disease, type IV (GBE1) <input type="checkbox"/> GTP cyclohydrolase I deficiency (GCH1) <input type="checkbox"/> Lesch-Nyhan syndrome (HPRT1) <input type="checkbox"/> Metachromatic leukodystrophy (ARSA) <input type="checkbox"/> Methylene tetrahydrofolate reductase deficiency (MTHFR) <input type="checkbox"/> Mevalonic aciduria (MVK) <input type="checkbox"/> Microcephaly, Amish type (SLC25A19) <input type="checkbox"/> Niemann Pick disease, type C1/C2 (NPC1, NPC2) <input type="checkbox"/> Ornithine transcarbamylase deficiency (OTC) <input type="checkbox"/> Transcobalamin II deficiency (TCN2)</p> <p><input type="checkbox"/> other rare or familial mutation (specify) _____</p> <p><u>Mitochondrial disorders:</u></p> <p><input type="checkbox"/> point mutations <input type="checkbox"/> 3243A>G (MELAS) <input type="checkbox"/> 3260A>G (myopathy) <input type="checkbox"/> 3303C>T (cardiomyopathy) <input type="checkbox"/> 8344A>G (MERRF) <input type="checkbox"/> 8993T>G/C (NARP/Leigh disease) <input type="checkbox"/> other rare or familial mutation (specify) _____</p> <p><input type="checkbox"/> mtDNA deletion analysis (Southern blot) <input type="checkbox"/> mtDNA depletion analysis (Southern blot) <input type="checkbox"/> hepatocerebral mtDNA depletion syndrome (DGUOK) <input type="checkbox"/> myopathic mtDNA depletion syndrome (TK2)</p> | <p><u>REASON FOR REFERRAL:</u></p> <p><input type="checkbox"/> Documented family history of indicated disease <input type="checkbox"/> Possible family history of indicated disease <input type="checkbox"/> Symptoms of indicated disease in this individual</p> <p><input type="checkbox"/> Other: _____</p> <p><u>INFORMATION REQUESTED :</u></p> <p><input type="checkbox"/> Bank until further notice <input type="checkbox"/> Confirm clinical diagnosis <input type="checkbox"/> Carrier status <input type="checkbox"/> None - for research only</p> <p><input type="checkbox"/> Other: _____</p> <p><u>SAMPLE COLLECTION:</u> Date Drawn: <u> </u> <u> </u> / <u> </u> <u> </u> / <u> </u> <u> </u></p> <p><input type="checkbox"/> EDTA blood (lavender top) _____ cc room temp <input type="checkbox"/> DNA _____ ng/μL <input type="checkbox"/> fibroblast culture <input type="checkbox"/> tissue (specify) _____ <input type="checkbox"/> prenatal (specify) _____</p> <p><input type="checkbox"/> Other _____</p> <p><u>AUTHORIZED SIGNATURE:</u></p> <p>_____</p> <p>Ordering Physician : (name, address)</p> |