Province of Ontario Molecular Diagnostic Laboratories

Requisition for DNA Testing

DACC002 REV 20080930

SEND TO:

- ❑ **LHSC Molecular Diagnostic Laboratory**
  Victoria Hospital, Room E3-304,
  800 Commissioners Road East,
  London Ontario, N6A 4G5
  Ph: (519) 685-8122
  Fax: (519) 685-8279

- ❑ **CHEO** DNA Diagnostic Laboratory (613) 738-3230
- ❑ **HSC** DNA Diagnostic Laboratory (416) 813-6590
- ❑ **KGH** DNA Diagnostic Laboratory (613) 548-3232 x4134
- ❑ **MUMC** Provincial Hemoglobinopathy DNA Diagnostic Lab (905) 521-2100 x3092
- ❑ **NYGH** Molecular Genetics Laboratory (416) 756-6791

AUTHORIZED SIGNATURE IS REQUIRED TO PROCEED WITH TESTING

Patient's Name: _____

Birthdate: __yy__ / __mm__ / __dd__

Patient's Address:

Health Card #: _____

FAMILY INFORMATION:

Have samples from this family been sent to a DNA lab before?

- ❑ Yes
- ❑ No

If Yes, specify _____

- ❑ This individual is the index case
- ❑ or Name of Index Case in the Family _____
  D.O.B. __yy__ / __mm__ / __dd__

Relationship to this patient: _____

PEDIGREE: (*Must be completed when indicated)

TEST REQUESTED:

- ❑ BCR-ABL (CML)
  White Blood Cell Count : _____
- ❑ Breast Cancer (BRCA1/BRCA2)*
  Referral through Cancer Genetics Clinic Only
- ❑ CADASIL (NOTCH3)
- ❑ Charcot-Marie Tooth X-Linked (GJB1)
- ❑ Charcot-Marie Tooth Type1A(PMP22)
- ❑ Charcot-Marie Tooth Type2B(MPZ)
- ❑ Charcot-Marie Tooth Type2A/I/J (MFN2)
- ❑ Cystic Fibrosis (CFTR)*
- ❑ Factor V Leiden (FV)
- ❑ Familial Amyloidotic Polyneuropathy (TTR)
- ❑ Hemochromatosis (HFE)
- ❑ Hereditary Sensory Neuropathy (SPTLC1)
- ❑ Cancer of the Colon –HNPCC (MLH1,MSH2)*
  Referral through Cancer Genetics Clinic Only
- ❑ Li-Fraumeni Syndrome (P53)
- ❑ Leber's Hereditary Optic Neuropathy (ND1,4,6)
- ❑ Medium Chain Acyl CoA Dehydrogenase (MCAD)
- ❑ Multiple Endocrine Neoplasia Type 1(MENIN)
- ❑ Myeloproliferative disorders (JAK2-V617F)
- ❑ Paramyotonia Congenita (SCN4A)
- ❑ Prothrombin (PTH)
- ❑ Recessive Deafness (CX26,CX30)
- ❑ Ret Oncogene (RET)*
- ❑ RETT Syndrome (MECP2)

- ❑ Other: _____

***PEDIGREE REQUIRED**

SAMPLE COLLECTION: Date Drawn: __yy__ / __mm__ / __dd__

- ❑ EDTA blood (lavender top) ____cc room temp
- ❑ ACD blood (yellow top) ____cc room temp
- ❑ amniotic fluid ____cc room temp
- ❑ CVS
- ❑ DNA ____ug
- ❑ Other _____

SEE WEB SITE FOR MORE INFORMATION:
www.lhsc.on.ca/lab/molegen/index.htm

REASON FOR REFERRAL:

- ❑ Documented family history of indicated disease
- ❑ Possible family history of indicated disease
- ❑ Symptoms of indicated disease in this individual
- ❑ Other:_____

PREGNANCY INFORMATION:

If this individual or the partner of individual is currently pregnant:

- ❑ **L.M.P.** __yy__ / __mm__ / __dd__
- ❑ **Amnio** __yy__ / __mm__ / __dd__
- ❑ **CVS** __yy__ / __mm__ / __dd__

AUTHORIZED SIGNATURE: _____

Ordering Physician :
(name, address)

INFORMATION REQUESTED :

- ❑ Confirm clinical diagnosis
- ❑ Carrier Status
- ❑ Prenatal Diagnosis
- ❑ None: for research only
- ❑ Bank DNA until further notice
- ❑ Other: _____

FOR SAMPLE REQUIREMENTS SEE: http://www.lhsc.on.ca/lab/molegen/index.htm