London Health Sciences Centre—Molecular Diagnostics

Requisition for Atypical Hemolytic Uremic Syndrome Variant Testing

Reason for Referral

☐ Diagnostic testing

☐ Affected

☐ Unaffected

Current Rx:_____

Clinical Presentation: _____

_____

_____

_____

Patient information:

Name: _____

Birthdate:(YY/MM/DD)_____

Address: _____

Sex: ☐ Male ☐ Female

Health Card Number: _____

Test Request:

Confirmation of detected variants or Familial variants

☐ Variant to be confirmed

gene: nucleotide change :_____

☐ Variant detected in related individual (Familial testing)

gene: nucleotide change :_____

Sample Collection:

Date Drawn (YY/MM/DD) : _____

☐ EDTA blood(lavender top) (5ml at room temp)

Clinical Diagnostics and Family History:

_____

_____

_____

AUTHORIZED SIGNATURE IS REQUIRED

Referring Physician:_____.

Signature: _____

Address: _____

Telephone: _____Fax:_____

$ Billing address:_____

_____

_____

Lab Use Only:

Received Date: _____

Notes:_____

_____

_____

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