CYTOGENETICS ROUTINE REQUISITION (Non-Cancer)

London Health Sciences Centre | St Joseph's Health Care London
Pathology and Laboratory Medicine

Regional Cytogenetics Laboratory
800 Commissioners Rd. East, North Tower, B10-114
London, ON N6A 5W9
P: 519-685-8500 x78974 F: 519-667-6720

Name
Address

DOB (YYYYMMDD)
Health Card #: Sex : M □ F□

Specimen Submission - SAMPLE MUST BE LABELED CORRECTLY OR WILL NOT BE PROCESSED

Transport all specimens at room temperature - **Do not fix, freeze or spin samples.**

***For indications of developmental delay, multiple congenital anomalies, autism or intellectual disability, please use the MICROARRAY REQUISITION.**

TESTING REQUESTED

□ Chromosome Analysis (G-banding; Karyotype)
- □ Peripheral Blood in sodium heparin (5-10mL for adults, 1-3mL for neonates/infants)
- □ Cord Blood (1-2mL in sodium heparin)
- □ AF □ CVS Gestational Age: _____
- □ Fetal Tissue/POC (specify) in HBSS _____Gestational Age: _____
- □ Other (specify) _____

□ Mosaicism
□ Cell Storage □ DNA Banking
□ Send Out □ Location_____
□ FISH: □ DiGeorge/VCF □ Williams □ Prader Willi/Angelman □ Other
□ Family Studies (Provide LHSC reference # or attach external lab report - Contact Lab)
□ QF-PCR (5mL peripheral blood in EDTA, 1-2mL EDTA for neonates/infants)
- □ Suspected aneuploidy (chr. 13, 18, 21, X, Y)

□ Maternal cell contamination studies
□ Identity/Zygosity Testing

CLINICAL INFORMATION (***Testing will not be performed without an indication)

- □ Suspected aneuploidy (chr. 13, 18, 21, X,Y)
- □ Recurrent miscarriage (≥ 3) □ Infertility
- □ Turner Syndrome □ Short stature
- □ Amenorrhea
- □ Ambiguous genitalia
- □ Stillbirth □ Neonatal Death
- □ Klinefelter Syndrome
- □ Breakage Syndrome (specify) _____

REPORTS TO:
Ordering Physician:
Address:

Phone: Fax:
Physician Signature

Additional Copies To:
Name:
Address: