## FAMILIAL HYPERCHOLESTEROLEMIA ONTARIO REQUISITION

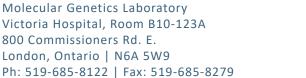
LAB USE ONLY	PATIENT INFORMATION (INCOMPLETE REQUESTS WILL BE BANKED)
Received date:	Name: Address:
SAMPLE COLLECTION   Date drawn:   YYYY/MM/DD   EDTA blood (lavender top) (5ml at room temp)   DNA (100ng minimum)	Date of Birth:   YYYY/MM/DD   Health Card No.:   Sex: M F   Unknown Unspecified   Birthsex: M F   Unknown Unspecified
TEST REQUEST	ELIGIBILITY CRITERIA FOR TESTING
Familial Hypercholesterolemia- Focused Panel (8 genes)   ABCG5, ABCG8, APOB, APOE, LDLR, LDLRAP1, LIPA, PCSK9   Carrier testing/Known Family Mutation   LHSC MD#/Name of index case in the family (include copy of report)   Date of Birth:   Relationship to this patient:   Gene:   RefSeq:NM:   Mutation:	Individual must meet one or more of the following:   1. Confirmed FH disease-causing pathogenic/likely pathogenic variant in a close blood relative   2. High LDL-cholesterol level of ≥8.5 mmol/L at any age   3. Untreated elevated LDL-cholesterol level (not due to secondary causes)   Specify: mmmol/L   Untreated LDL-cholesterol level ≥5.0 mmol/L for age 40 years and over   Untreated LDL-cholesterol level ≥4.5 mmol/L for age 18 to 39 years   Untreated LDL-cholesterol level ≥3.5 mmol/L for age under 18 years   AND at least one of the following:   Tendon xanthomas and/or corneal arcus in proband   First-degree relative (FDR) with high LDL- cholesterol level (not due to secondary causes)   Proband or FDR with early onset ASCVD (men under 55 years; women under 65 years)   Limited family history information (e.g., adopted)   4. Clinical judgement:Criteria above not met, but suspicion remains: Describe:

## **REFERRING PHYSICIAN**

Authorized Signature is Required

## **CC REPORT TO**

Physician Name (print):		Name:
Signature:	Email:	Address:
Clinic/Hospital:		
Address:		Telephone:
Telephone:	Fax:	Fax:





(11/09/2023)