FAMILIAL HYPERCHOLESTEROLEMIA ONTARIO REQUISITION

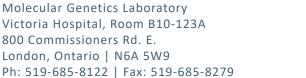
LAB USE ONLY	PATIENT INFORMATION (INCOMPLETE REQUESTS WILL BE BANKED)
Received date:	Name: Address:
SAMPLE COLLECTION Date drawn: YYYY/MM/DD EDTA blood (lavender top) (5ml at room temp) DNA (100ng minimum)	Date of Birth: YYYY/MM/DD Health Card No.: Sex: M F Unknown Unspecified Birthsex: M F Unknown Unspecified
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)