Atypical Hemolytic Uremic Syndrome Variant Testing

LAB USE ONLY

Date Received:

Notes:

REASON FOR REFERRAL

◯ Diagnostic Testing:
- ◯ Affected
- ◯ Unaffected

Current Rx:

Clinical Presentation:

TEST REQUEST

Confirmation of detected variants or Familial variants

◯ Variant to be confirmed

Gene: RefSeq:NM:

Mutation:

◯ Carrier testing/Known Family Mutation

LHSC MD#/Name of Index case in the family (include copy of report):

Date of Birth (YYYY/MM/DD):

Relationship to this patient:

Gene: RefSeq:NM:

Mutation:

PATIENT INFORMATION

INCOMPLETE REQUESTS WILL BE BANKED

Name:

Address:

Date of Birth: YYYY/MM/DD

Health Card No.:

Sex: ◯ M ◯ F ◯ Unknown ◯ Unspecified

Birthsex: ◯ M ◯ F ◯ Unknown ◯ Unspecified

SAMPLE COLLECTION

Date Drawn: YYYY/MM/DD

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

◯ DNA (100ng minimum) Conc:

REFERRING PHYSICIAN:

Authorized Signature is Required

Physician Name (print):

Signature:

Email:

Clinic/Hospital:

Address:

Telephone: Fax:

cc Report to:

Name:

Address:

Telephone: Fax:

Molecular Genetics Laboratory
Victoria Hospital, Room B10-123A
800 Commissioners Rd. E.
London, Ontario | N6A 5W9
Ph: 519-685-8122 | Fax: 519-685-8279

London Health Sciences Centre
Pathology and Laboratory Medicine

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