Cytogenetics Routine Requisition (Constitutional)

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

COLLECTION INFORMATION

Da	ate (yyyy/mm/dd):
Tir	me (00:00hr):
Co	ollected By:

PATIENT INFORMATION

PATIENT INFORMATION						
Medical Record No.:						
Health Card No.:						
Last Name:						
First Name:						
Date of Birth (yyyy/mm/dd):						
Sex:	М	F	Unspecified	Unknown		
Birthsex:	М	F	Unspecified	Unknown		

CLINICAL INFORMATION

(Testing will not be performed without an indication)

Suspected aneuploidy (chr. 13, 18, 21, X, Y)

Suspected Mosaicism Infertility

Recurrent miscarriage (≥3) Short Stature

Turner Syndrome Stillbirth

Amenorrhea Klinefelter Syndrome Ambiguous genitalia Neonatal Death

*For indications of DiGeorge/VCF syndrome, Williams syndrome, developmental delay, multiple congenital anomalies, autism or intellectual disability, please use the MICROARRAY REQUISITION

Cytogenetics Tests

TEST REQUEST

Chromosome Karyotype Analysis (G-banding)

Family Chromosome Studies (provide LHSC reference #):

Direct Send Out Cell Culture Send Out

(attach requisition)

Accepted Sample Types (for Cytogenetics)

Peripheral Blood in dark green **NaHep** (2-3 ml)
Amniotic Fluid Chorionic Villus
Fetal Tissue/POC in **HBSS** (specify source):

Gestational Age for Prenatal Samples:

Molecular Cytogenetics Tests

Rapid Aneuploidy Detection (QF-PCR for chr. 13, 18, 21, X, Y)

DNA Banking

Maternal Cell Contamination Studies

Identity/Zygosity Testing

Banked Cytogenetics DNA Send Out (attach requisition)

Accepted Sample Types (for Molecular Cytogenetics)

Peripheral Blood in purple EDTA (2-3 ml)

Cord Blood in purple EDTA

Amniotic Fluid Chorionic Villus Fetal Tissue/POC in **HBSS** (specify source):

Gestational Age for Prenatal Samples:

FFPE tissue (reference #):

SPECIMEN INFORMATION: Specimen Submission must be labelled correctly or will not be processed. Transport all specimens at room temperature. Do not fix, freeze or spin samples.

Regional Cytogenetics Laboratory
Victoria Hospital, Room B10-114
800 Commissioners Rd. E.
London, ON | N6A 5W9
Ph: 519-685-8500 x 78974 | Fax: 519-667-6720

Visit community collection lab for blood draw.

