SickKids®

Paediatric Laboratory Medicine

MOLECULAR GENETICS Requisition

MOLECULAR GENETICS LABORATORY (CLIA # 99D1014032)
Roy C. Hill Wing Rm 3421
555 University Ave
Toronto ON M5G 1X8 Canada
Tel: (416) 813-7200 x1
Fax: (416) 813-7732

Patient Name
Birthdate (YYYY-MM-DD)
Sex
Parent's Name
Address

Telephone #

For Canada Only:

Provincial Health Card # _____ *Version* _____
Issuing Province _____

Referring physician: *(Please Print)*

Name:

Address:

Tel ( ) _____ Fax ( ) _____

e-mail address:

Signature *(required)* _____

CC report to:

Name:

Address:

Tel ( ) _____ Fax ( ) _____

Sample information:

Date obtained (YYYY-MM-DD): _____ -_____-_____

Your Referring Laboratory Reference #: _____

❒ Blood (Room Temp.): 1 Full EDTA tube (min. 4mL) (purple)
0.5-3 mL EDTA- *Infant/Newborn*
❒ Amniotic fluid: 10 mL minimum
❒ CVS: 10 mg minimum
❒ Cultured cells: 1-2 confluent T25 flask(s) required
❒ DNA: 10 ug minimum (in low TE (pH8.0))

❒ Other (specify) _____

Laboratory Use:

Date/Time Received (YYYY-MM-DD):

_____-_____-_____ _____h

Lab #: _____

Specimen type, amt & # of tubes: _____

Comments:

Pedigree No. / Patient No. _____ / _____

Test request:

Write gene/disease name below or check box on pages 2 and 3.

_____

❒ Testing for a known mutation:
Gene: _____ Mutation: _____
SicKids laboratory number of relative: _____

Reason for referral:

❒ Diagnostic testing
❒ Carrier testing
❒ Prenatal Diagnosis
❒ Family study
❒ Family mutation
❒ Bank
❒ Other (specify) _____

If expedited testing is requested, please indicate reason:

❒ Pregnancy (gestational age: _____weeks)
❒ Other (specify): _____

Clinical diagnostics and family history:

(Please provide relevant information below, including the names of any relatives previously tested). Please provide a pedigree, if possible.

Ethnicity: _____

Ordering checklist:

❒ Completed requisition
❒ Specimen tube labeled *(with at least two identifiers)*
❒ Complete Clinical datasheet *(if applicable)*
❒ Tay Sachs requisition *(if applicable)*

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Patient Name

Birthdate (YYYY-MM-DD)

Sex

Molecular Genetics TESTING

❒ **22q11 Deletion Syndrome gene dosage**

Angelman Syndrome
- ❒ methylation and copy number
- ❒ UPD 15 analysis *(please send parental samples)*

AR Hereditary Spastic Paraplegia panel*
- ❒ Panel A
  - ❒ SPG11 gene sequencing
  - ❒ SACS gene sequencing
  - ❒ CYP7B1 gene sequencing
- ❒ Panel B
  - ❒ SPG15 gene sequencing
  - ❒ SPG7 gene sequencing
  - ❒ PNPLA6 s gene equencing
- ❒ Panel C
  - ❒ SPG 20 gene sequencing
  - ❒ SPG21 gene sequencing
  - ❒ CCT5 gene sequencing
- ❒ Familial mutation

Arrhythmogenic Right Ventricular Atrophy*
- ❒ Full panel
  - ❒ DSC2 gene sequencing
  - ❒ DSG2 gene sequencing
  - ❒ DSP gene sequencing
  - ❒ PKP2 gene sequencing
  - ❒ TMEM43 gene sequencing
- ❒ Familial mutation

❒ **Ashkenazi Jewish Screening panel**

Atypical Hemolytic Uremic Syndrome / Membranoproliferative Glomerulonephritis*
- ❒ Panel A
  - ❒ CD46 gene sequencing
  - ❒ CFB gene sequencing
  - ❒ CFH gene sequencing
  - ❒ CFHR5 gene sequencing
  - ❒ CFI gene sequencing
- ❒ Panel B
  - ❒ C3 gene sequencing
  - ❒ THBD gene sequencing
  - ❒ APLN gene sequencing
- ❒ Familial mutation

Batten disease
- ❒ Recurrent mutation panel
- ❒ Full Panel
  - ❒ CLN1 gene sequencing
  - ❒ CLN2 gene sequencing
  - ❒ CLN3 gene sequencing
  - ❒ CLN5 gene sequencing
  - ❒ CLN6 gene sequencing
  - ❒ CLN7 gene sequencing
  - ❒ CLN8 gene sequencing
  - ❒ CLN10 gene sequencing
- ❒ Familial mutation

Beckwith-Wiedemann Syndrome
- ❒ methylation and copy number
- ❒ CDKN1C gene sequencing
- ❒ CDKN1C gene sequencing *(if methylation is normal)*
- ❒ UPD 11 analysis *(please send parental samples)*
- ❒ Familial mutation

Bone Marrow Transplant
- ❒ BMT - monitoring

Branchio-Oto-Renal Syndrome
- ❒ EYA1 gene sequencing
- ❒ EYA1 gene dosage
- ❒ Familial mutation

Charge Syndrome (CHD7)
- ❒ CHD7 gene sequencing
- ❒ CHD7 gene dosage
- ❒ Familial mutation

Cherubism*
- ❒ SH3BP2 recurrent mutation in exon 9
- ❒ SH3BP2 gene sequencing

Congenital Muscular Dystrophy
- ❒ Full panel
  - ❒ FCMD gene sequencing
  - ❒ FKRP gene sequencing
  - ❒ POMGnT1 gene sequencing
  - ❒ POMT1 gene sequencing
  - ❒ POMT2 gene sequencing
- ❒ Familial mutation

Craniosynostosis
- ❒ Apert/Pfeiffer Syndrome *(recurrent mutation in FGFR1 gene)*
- ❒ Crouzon Syndrome (*select exons of FGFR2 and FGFR3 gene*)
- ❒ Saethre-Chotzen Syndrome *(TWIST seq & select exons in FGFR3)*
- ❒ Craniosynostosis Non-Syndromic *(select exons of FGFR3 gene)*
- ❒ Gene dosage for FGFR2, FGFR3 & TWIST

Cystic Fibrosis
- ❒ CFTR mutation panel
- ❒ CFTR gene sequencing
- ❒ CFTR gene dosage
- ❒ Familial mutation

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Birthdate (YYYY-MM-DD)

Sex

Molecular Genetics TESTING

Dopamine beta-hydroxylase deficiency
- ❒ DBH gene sequencing

Duchenne Muscular Dystrophy
- ❒ DMD gene dosage
- ❒ DMD gene sequencing
- ❒ DMD gene mRNA analysis *(contact the laboratory)*
- ❒ Familial mutation

Becker Muscular Dystrophy
- ❒ DMD gene dosage

Fabry Disease
- ❒ GLA gene sequencing
- ❒ GLA gene dosage
- ❒ GLA gene mRNA analysis *(contact the laboratory)*
- ❒ Familial mutation

Focal Segmental Glomerulosclerosis*
- ❒ Full panel
  - ❒ ACTN4 gene sequencing
  - ❒ CD2AP gene sequencing
  - ❒ NPHS1 gene sequencing
  - ❒ NPHS2 gene sequencing
  - ❒ TRPC6 gene sequencing
- ❒ Familial mutation

❒ **Fragile X (FMR1)**

❒ **Fragile X E (FMR2)**

❒ **Gaucher Disease (recurrent mutations)**

Hearing Impairment
- ❒ Full panel

  Non-syndromic genes
  - ❒ GJB2 gene sequencing and GJB6 deletion
  - ❒ GJB2 gene sequencing only
- ❒ Aminoglycoside-Induced or Maternally Inherited Hearing Loss (MTRNR1 (12s rRNA), MTTS1 (tRNA-SER))

  Pendred Syndrome/Hearing loss with EVA
  - ❒ SLC26A4 gene sequencing
  - ❒ SLC26A4 gene dosage
- ❒ Familial mutation

Hereditary Hemorrhagic Telangiectasia
- ❒ ACVRL1 gene sequencing
- ❒ ENG gene sequencing
- ❒ SMAD4 gene sequencing
- ❒ ACVRL1 & ENG gene dosage
- ❒ Familial mutation

Hunter Disease
- ❒ IDS gene sequencing
- ❒ IDS gene dosage analysis
- ❒ IDS gene mRNA analysis *(contact the laboratory)*
- ❒ Familial mutation

Identity studies
- ❒ Maternal cell contamination studies
- ❒ Zygosity studies

Li-Fraumeni Syndrome*
- ❒ TP53 gene sequencing
- ❒ TP53 gene dosage
- ❒ Familial mutation

Prader-Willi Syndrome
- ❒ methylation and copy number
- ❒ UPD 15 analysis *(please send parental samples)*

Russel Silver Syndrome
- ❒ H19 methylation & copy number
- ❒ UPD 7 analysis *(please send parental samples)*

Schwachman-Diamond Syndrome
- ❒ SBDS gene sequencing

Simpson-Golabi-Behmel Syndrome
- ❒ GPC3 gene sequencing
- ❒ GPC3 & GPC4 gene dosage
- ❒ Familial mutation

Skeletal Dysplasia
- ❒ Achondroplasia *(recurrent mutation in FGFR3)*
- ❒ Hypochondroplasia *(recurrent mutation in FGFR3)*
- ❒ Thanatophoric dysplasia *(recurrent mutation in FGFR3)*

❒ **Spinal and Bulbar Muscular Atrophy (SBMA) (AR gene)**

Spinal Muscular Atrophy (SMA)
- ❒ SMN1 & SMN2 gene dosage

Trismus-Pseudocamptodactyly (TRISM)
- ❒ MYH8 gene sequencing

❒ **X Inactivation Analysis**

❒ **Other:**

* Clinical datasheet required. Please contact the laboratory to obtain this form.

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LABORATORY TESTING: Billing Form

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Completion of Billing Form NOT required for patients with an Ontario Health Card Number

At your direction, we will bill the hospital, referring laboratory, referring physician, or a patient/guardian, for the services we render

- Invoices are sent upon completion of each test/service.
- Invoices are itemized and include the date of service, patient name, CPT code, test name and charge.
- Contact SickKids' Molecular Genetics Laboratory at (416) 813- 7200 x1 with billing inquiries.

How to complete the Billing Form:

- **Referring Physician completes the appropriate section below to specify billing method.**
- **Send requisition and completed "Billing Form" with specimen.**

Section 1: Complete to have the Healthcare Provider billed:

Your Referring Laboratory's Reference #: _____

Billing address of hospital, referring laboratory, clinic, referring physician, or medical group: (if different from requisition):

Name: _____
Address: _____
City: _____ Prov/State: _____
Postal/Zip Code: _____ Country: _____

Section 2: Complete to have Patient/Guardian billed directly:

If you elect to have patient/guardian billed:

- *Patient/Guardian billing information below must be complete; otherwise, the healthcare provider will be billed.*
- *Please advise the patient/guardian to expect a bill from our laboratory.*
- *Provide us with patient's valid credit card information.*
- *Unfortunately, we cannot accept personal checks.*
- ***In this case, the patient/guardian is solely responsible for the charges.***

Send bill to (check one): ❒ Patient ❒ Guardian

Method of Payment (check one): ❒ American Express ❒ Master Card ❒ Visa

Name as it appears on credit card: _____
Credit card # : _____
Expiry date on credit card: _____
Signature of credit card holder (Required): _____

Mailing Address of Patient/Guardian (if different from requisition):

Name: _____
Address: _____ Apt.# _____
City: _____ Prov/State: _____
Postal/Zip Code: _____ Country: _____

Additional Contact information:

Patient's phone # with area code: ( ) _____ - _____
or
Guardian's phone # with area code: ( ) _____ - _____