Newfoundland Labrador

CL2160 0011 05 2019

HCN:

Province/Territory: ___ Expiry: YYYY / MON / DD

Name: First Middle Surname

Date of Birth: YYYY / MON / DD Sex: ☐ M ☐ F ☐ UN

Mailing Address:_____

City: _____ Prov/Terr:_____ Postal Code:_ _ _ _ _ _

Telephone: (Indicate Preferred) ☐ Home (_ _ _) - _ _ _ - _ _ _ _

☐ Cell (_ _ _) -_ _ _-_ _ _ _ ☐ Work (_ _ _) - _ _ _ - _ _ _ _

Molecular Genetics Laboratory Requisition

Ordering Provider's Name:_____

Clinic Name: _____

Mailing Address:_____

City:_____ Prov/Terr: _____Postal Code: _ _ _ _ _ _

Phone: (_ _ _) -_ _ _- _ _ _ _ Fax: (_ _ _) -_ _ _- _ _ _ _

Ordering Provider's Meditech Mnemonic:_____

Signature:_____Date: YYYY / MON / DD

Clinic Stamp:(include fax, provider and mnemonics)

EMR Clinic Mnemonic:_____

COPY TO PROVIDER _____

By completing this requisition, the ordering physician attests appropriate genetic counselling was provided.
PLEASE COMPLETE ALL SECTIONS - Incomplete requisitions will delay testing.

Previously tested family members? ☐ Yes ☐ No Index Case: _____

Will testing alter the management of an ongoing pregnancy? ☐ Yes ☐ No LMP: YYYY / MON / DD

Recent transfusion/transplant? ☐ Yes ☐ No Date: YYYY / MON / DD

I. Specimen Requirements

☐ Peripheral blood - **EDTA/Lavender** (☐ Adults | 4-8 mL ☐ Children | 4-5 mL ☐ Infants | 2-5 mL) ☐ Bone Marrow - **EDTA/Lavender** (1-2 mL)

☐ Amniotic Fluid (5 mL) ☐ Cell Pellet ☐ Frozen Tissue ☐ Fresh Tissue ☐ FFPE Block ☐ Other ☐ Reflex from MG#

II. Reason for Referral

☐ Carrier Status
☐ Presymptomatic Testing
☐ Confirmation of Clinical Diagnosis
☐ Prenatal Testing
☐ DNA Banking Only
☐ DNA Banking-Testing also required
☐ Other:

III. Medical History

☐ Symptoms of Indicated Disease

☐ Asymptomatic (currently)

IV. Family History of Indicated Disease

☐ No Family History
☐ Documented Family History; Mutation:
☐ Possible Family History
☐ Unknown Family History

Relevant Clinical Information/Pedigree (attach additional page if necessary):

V. Test Menu - No Referral from Medical Genetics Required

☐ Ankylosing Spondylitis | *HLA*-B27
☐ Hemochromatosis | *HFE* p.C282Y; p.H63D -------> Transferrin Saturation Level: _____ (Required)
☐ Thrombophilia | *FVL* c.1601G>A | *FII* c.*97G>A (Restricted to medical geneticists, hematologists and in the stillbirth setting)

VI. Test Menu - Restricted to Medical Geneticists

☐ ARVC5 | *TMEM43* c.1073C>T
☐ Cystic Fibrosis
☐ *FMR1* related disorders
  ☐ Fragile X ☐ Primary Ovarian Insufficiency ☐ FXTAS
☐ Fragile X E Syndrome | *FMR2*
☐ HCM | *MYBPC3* c.2864delCT
☐ HMA Twillingate | *F8* c.6104T>C
☐ Huntington Disease | *HTT*
☐ Non-Syndromic Hearing Loss | *GJB2* c.35delG
☐ Rapid Aneuploidy Detection
☐ Other:

☐ Gastric Cancer
  ☐ *CDH1* c.2398delC ☐ *CDH1* recurrent mutation panel
☐ Hereditary Breast Cancer and Ovarian Cancer
  ☐ *BRCA1* c.2071delA ☐ Known family mutation_____
☐ Hereditary Colorectal Cancer
  ☐ Non-Polyposis Colorectal Cancer (HNPCC)
  ☐ *MSH2* c.942+3A>T ☐ *MSH2* exon 8 deletion
  ☐ Known family mutation _____
☐ MAP | *MUTYH* p.Y165C; p.G382D
☐ MEN1 Burin | *MEN1* p.R465X
☐ Other:

☐ **External Reference Facility**: Test: Location: Requisition: ☐ Attached ☐ To Follow

VII. Test Menu - Restricted to Hematologists/Medical Oncologists ***Specimens received in the Genetics Lab after Friday morning are subject to cancellation***

APL	☐ Qualitative *PML/RARa*	☐ Quantitative *PML/RARa*	
CML/ALL	☐ Qualitative *BCR/ABL1*	☐ Quantitative *BCR/ABL1*	☐ p190 ☐ p210 ☐ p230
MPD	☐ *JAK2* p.V617F		

MG# **Date Received:** YYYY / MON / DD **Specimen Received:**

Clear Form Print Form

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