



# Cytogenetics Constitutional Studies Requisition

## Royal Columbian Hospital Molecular Cytogenetics Laboratory

Rm B180 - 330 East Columbia Street, New Westminster, BC V3L 3W7  
 Tel:(604) 520-4484 Fax:(604) 520-4149

Patient Information		Physician Information
Patient Name  Last <span style="margin-left: 150px;">First</span>		Ordering Physician (Name and Billing #)
Date of Birth (DD/MM/YYYY)	PHN	Additional Reports to (Name and Billing #)
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Medical Genetics #	
Patient Address		
Patient Phone #		

**Note:** All Non-Canadian Residents must sign a FHA waiver form. The signed and witnessed form must be attached to the requisition when the specimen is submitted.

**Further Collection Information and Waiver Form** [Molecular Cytogenetics Specimen Collection and Submission](#)

Personal History	
Known/Relevant Clinical Diagnosis:	Relevant Family History and Consanguinity:
Previous Cytogenetic Analysis: <input type="checkbox"/> Yes <input type="checkbox"/> No Cytogenetics Accession # _____	

**Specimen Type: Peripheral Blood**

Collection Date: \_\_\_\_\_ **3 mL Sodium Heparin and 2 x 3 mL EDTA**

**Newborn Infants (< 1 month): minimum 1 mL Sodium Heparin and 1 mL EDTA**

Test Requested	Indication: Please check all that apply				
<input type="checkbox"/> <b>Karyotype</b>	<input type="checkbox"/> Trisomy 21 <input type="checkbox"/> Trisomy 18 <input type="checkbox"/> Trisomy 13 <input type="checkbox"/> Turner syndrome <input type="checkbox"/> Klinefelter syndrome <input type="checkbox"/> Ambiguous genitalia <input type="checkbox"/> Family history of chromosomal abnormality (specify): _____ <input type="checkbox"/> Recurrent Pregnancy Loss (RPL) <input type="checkbox"/> Infertility <input type="checkbox"/> Patient/partner is currently pregnant Partner: _____ PHN: _____				
<input type="checkbox"/> <b>Molecular Testing</b>	<input type="checkbox"/> Fragile X syndrome <input type="checkbox"/> Other (specify): _____ EDTA will be sent to BCCWH MGL if a molecular test is requested that is not performed at RCH.				
<input type="checkbox"/> <b>FISH</b>	<input type="checkbox"/> Suspected syndrome (specify): _____ <input type="checkbox"/> Known Familial Microdeletion/Microduplication syndrome (specify): _____				
<input type="checkbox"/> <b>Microarray Follow-up</b>	FISH custom probe: _____ <input type="checkbox"/> Proband Cytogenetics Acc. # _____ <input type="checkbox"/> Family Member: _____ Relationship to proband: _____				
<input type="checkbox"/> <b>Microarray</b>	<table style="width: 100%; border: none;"> <tr> <td style="width: 25%; vertical-align: top; border: none;"> <b>Behavioural/Psychiatric</b>  <input type="checkbox"/> Autism/ASD  <input type="checkbox"/> ADHD  <input type="checkbox"/> Psychiatric disorder (specify):  <input type="checkbox"/> Bipolar <input type="checkbox"/> Schizophrenia  <input type="checkbox"/> Other: _____   <b>Growth Parameters</b>  <input type="checkbox"/> IUGR  <input type="checkbox"/> Failure to thrive  <input type="checkbox"/> Microcephaly <input type="checkbox"/> Macrocephaly  <input type="checkbox"/> Macrosomia (&gt; 95% ile)  <input type="checkbox"/> Short stature (&lt; 5% ile)  <input type="checkbox"/> Other: _____   <b>Genitourinary</b>  <input type="checkbox"/> Ambiguous genitalia  <input type="checkbox"/> Hypospadias  <input type="checkbox"/> Undescended testes  <input type="checkbox"/> Other: _____               </td> <td style="width: 25%; vertical-align: top; border: none;"> <b>Developmental/Cognitive</b>  <input type="checkbox"/> Global dev. delay  <input type="checkbox"/> Fine motor delay  <input type="checkbox"/> Gross motor delay  <input type="checkbox"/> Speech/Language delay  <input type="checkbox"/> Learning disability  <input type="checkbox"/> Intellectual disability  <input type="checkbox"/> Other: _____   <b>Craniofacial</b>  <input type="checkbox"/> Dysmorphic facial features  <input type="checkbox"/> Hypotelorism  <input type="checkbox"/> Hypertelorism  <input type="checkbox"/> Deafness  <input type="checkbox"/> Low set/Abnormal ears  <input type="checkbox"/> Cleft lip/Cleft palate  <input type="checkbox"/> Coloboma of eye  <input type="checkbox"/> Craniosynostosis  <input type="checkbox"/> Other: _____               </td> <td style="width: 25%; vertical-align: top; border: none;"> <b>Neurological</b>  <input type="checkbox"/> Seizures <input type="checkbox"/> Ataxia  <input type="checkbox"/> Hypotonia <input type="checkbox"/> Dystonia  <input type="checkbox"/> Spasticity <input type="checkbox"/> Chorea  <input type="checkbox"/> Neural tube defect  <input type="checkbox"/> Structural brain abnormality  <input type="checkbox"/> Other: _____   <b>Musculoskeletal</b>  <input type="checkbox"/> Contractures  <input type="checkbox"/> Clubfoot  <input type="checkbox"/> Diaphragmatic hernia  <input type="checkbox"/> Limb anomaly  <input type="checkbox"/> Polydactyly <input type="checkbox"/> Syndactyly  <input type="checkbox"/> Vertebral anomaly  <input type="checkbox"/> Other: _____               </td> <td style="width: 25%; vertical-align: top; border: none;"> <b>Gastrointestinal</b>  <input type="checkbox"/> Gastroschisis  <input type="checkbox"/> Anal atresia  <input type="checkbox"/> Omphalocele  <input type="checkbox"/> Pyloric stenosis  <input type="checkbox"/> Tracheoesophageal fistula  <input type="checkbox"/> Other: _____   <b>Cardiac</b>  <input type="checkbox"/> ASD <input type="checkbox"/> VSD  <input type="checkbox"/> AV canal defect  <input type="checkbox"/> Coarctation of aorta  <input type="checkbox"/> Hypoplastic left heart  <input type="checkbox"/> Tetralogy of Fallot  <input type="checkbox"/> Other: _____               </td> </tr> </table>	<b>Behavioural/Psychiatric</b> <input type="checkbox"/> Autism/ASD <input type="checkbox"/> ADHD <input type="checkbox"/> Psychiatric disorder (specify): <input type="checkbox"/> Bipolar <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other: _____  <b>Growth Parameters</b> <input type="checkbox"/> IUGR <input type="checkbox"/> Failure to thrive <input type="checkbox"/> Microcephaly <input type="checkbox"/> Macrocephaly <input type="checkbox"/> Macrosomia (> 95% ile) <input type="checkbox"/> Short stature (< 5% ile) <input type="checkbox"/> Other: _____  <b>Genitourinary</b> <input type="checkbox"/> Ambiguous genitalia <input type="checkbox"/> Hypospadias <input type="checkbox"/> Undescended testes <input type="checkbox"/> Other: _____	<b>Developmental/Cognitive</b> <input type="checkbox"/> Global dev. delay <input type="checkbox"/> Fine motor delay <input type="checkbox"/> Gross motor delay <input type="checkbox"/> Speech/Language delay <input type="checkbox"/> Learning disability <input type="checkbox"/> Intellectual disability <input type="checkbox"/> Other: _____  <b>Craniofacial</b> <input type="checkbox"/> Dysmorphic facial features <input type="checkbox"/> Hypotelorism <input type="checkbox"/> Hypertelorism <input type="checkbox"/> Deafness <input type="checkbox"/> Low set/Abnormal ears <input type="checkbox"/> Cleft lip/Cleft palate <input type="checkbox"/> Coloboma of eye <input type="checkbox"/> Craniosynostosis <input type="checkbox"/> Other: _____	<b>Neurological</b> <input type="checkbox"/> Seizures <input type="checkbox"/> Ataxia <input type="checkbox"/> Hypotonia <input type="checkbox"/> Dystonia <input type="checkbox"/> Spasticity <input type="checkbox"/> Chorea <input type="checkbox"/> Neural tube defect <input type="checkbox"/> Structural brain abnormality <input type="checkbox"/> Other: _____  <b>Musculoskeletal</b> <input type="checkbox"/> Contractures <input type="checkbox"/> Clubfoot <input type="checkbox"/> Diaphragmatic hernia <input type="checkbox"/> Limb anomaly <input type="checkbox"/> Polydactyly <input type="checkbox"/> Syndactyly <input type="checkbox"/> Vertebral anomaly <input type="checkbox"/> Other: _____	<b>Gastrointestinal</b> <input type="checkbox"/> Gastroschisis <input type="checkbox"/> Anal atresia <input type="checkbox"/> Omphalocele <input type="checkbox"/> Pyloric stenosis <input type="checkbox"/> Tracheoesophageal fistula <input type="checkbox"/> Other: _____  <b>Cardiac</b> <input type="checkbox"/> ASD <input type="checkbox"/> VSD <input type="checkbox"/> AV canal defect <input type="checkbox"/> Coarctation of aorta <input type="checkbox"/> Hypoplastic left heart <input type="checkbox"/> Tetralogy of Fallot <input type="checkbox"/> Other: _____
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<b>Ordering Physician Signature (Required)</b>	<b>Date (DD/MM/YYYY)</b>
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