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

Patient Name

Last First

Date of Birth (DD/MM/YYYY) | PHN

Sex: ☐ M ☐ F | Medical Genetics #

Patient Address

Patient Phone #

Physician Information

Ordering Physician (Name and Billing #)

Additional Reports to (Name and Billing #)

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:

Previous Cytogenetic Analysis: ☐ Yes ☐ No Cytogenetics Accession # _____

Relevant Family History and Consanguinity:

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, however we will attempt all newborn specimens.**

Test Requested **Indication:** Please check all that apply

☐ Karyotype

- ☐ Trisomy 21
- ☐ Trisomy 18
- ☐ Trisomy 13
- ☐ Turner syndrome
- ☐ Klinefelter syndrome
- ☐ Ambiguous genitalia
- ☐ Family history of chromosomal abnormality (specify):_____
- ☐ Recurrent Pregnancy Loss (RPL)
- ☐ Infertility

Partner:_____
PHN_____

- ☐ Patient/partner is currently pregnant

☐ Molecular Testing

- ☐ Fragile X syndrome
- ☐ Other (specify):_____

EDTA will be sent to BCCWH MGL if a molecular test is requested that is not performed at RCH.

☐ FISH

- ☐ Suspected syndrome (specify): _____
- ☐ Known Familial Microdeletion/Microduplication syndrome (specify):_____

☐ Microarray Follow-up

FISH custom probe: ☐ Proband Cytogenetics Acc. #_____ ☐ Family Member: _____ Relationship to proband:_____

☐ Microarray

Behavioural/Psychiatric

- ☐ Autism/ASD
- ☐ ADHD
- ☐ Psychiatric disorder (specify):
  - ☐ Bipolar ☐ Schizophrenia
- ☐ Other:_____

Growth Parameters

- ☐ IUGR
- ☐ Failure to thrive
- ☐ Microcephaly ☐ Macrocephaly
- ☐ Macrosomia (> 95% ile)
- ☐ Short stature (< 5% ile)
- ☐ Other:_____

Genitourinary

- ☐ Ambiguous genitalia
- ☐ Hypospadius
- ☐ Undescended testes
- ☐ Other:_____

Developmental/Cognitive

- ☐ Global dev. delay
- ☐ Fine motor delay
- ☐ Gross motor delay
- ☐ Speech/Language delay
- ☐ Learning disability
- ☐ Intellectual disability
- ☐ Other:_____

Craniofacial

- ☐ Dysmorphic facial features
- ☐ Hypotelorism
- ☐ Hypertelorism
- ☐ Deafness
- ☐ Low set/Abnormal ears
- ☐ Cleft lip/Cleft palate
- ☐ Coloboma of eye
- ☐ Craniosynostosis
- ☐ Other:_____

Neurological

- ☐ Seizures ☐ Ataxia
- ☐ Hypotonia ☐ Dystonia
- ☐ Spasticity ☐ Chorea
- ☐ Neural tube defect
- ☐ Structural brain abnormality
- ☐ Other:_____

Musculoskeletal

- ☐ Contractures
- ☐ Clubfoot
- ☐ Diaphragmatic hernia
- ☐ Limb anomaly
- ☐ Polydactyly ☐ Syndactyly
- ☐ Vertebral anomaly
- ☐ Other:_____

Gastrointestinal

- ☐ Gastroschisis
- ☐ Anal atresia
- ☐ Omphalocele
- ☐ Pyloric stenosis
- ☐ Tracheoesophageal fistula
- ☐ Other:_____

Cardiac

- ☐ ASD ☐ VSD
- ☐ AV canal defect
- ☐ Coarctation of aorta
- ☐ Hypoplastic left heart
- ☐ Tetralogy of Fallot
- ☐ Other:_____

☐ **Other**:_____

Ordering Physician Signature (Required) **Date (DD/MM/YYYY)**