Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

Internal Lab use only

CR# or Hospital ID #: ______________________

Patient Name: ____
(Last) (First)

Date of Birth (YYYY/MM/DD): _____/_____/_____ **Sex: M/F**

Health Card #: ____________________________ **Expiry Date:** _________

Address: ____

Postal Code: ________________ **Phone:** ________________________

Molecular Genetics Laboratory Requisition Form

76 Stuart Street, Douglas 4, Room 8-415
Kingston, ON K7L 2V7
Tel: (613)549-6666 ext. 4892
FAX: 613-548-1356
In-house delivery tube station: #31
http://www.kgh.on.ca/healthcare-providers/lab-requisition-forms

Specimen Requirements

Collection Centre: ___________________________ Collected by: ___________________________(please print)

Date (YYYY/MM/DD): ________/____/____ Time: ___________ ☐Collected at Room Temperature

Note: The requisition and specimen must carry the same two unique patient identifiers or the sample may be rejected

Blood (EDTA -Lavender or Pink)	**Prenatal Specimen** (notify lab)	
☐ Adult -10 cc ☐ Pediatric - 3 cc	☐ Cultured Amniocytes - 2 x T25 Flasks	☐ DNA 5-15 µg
☐ Cord Blood -10 cc	☐ Cultured CVS - 2 x T25 Flasks	☐ Other (specify):____________

Molecular Genetics Tests

☐ Amyloidosis
☐ Factor V Leiden & Prothrombin
☐ Fragile X Syndrome
☐ Hemochromatosis
☐ Hemophilia A
☐ Hemophilia B
☐ MTHFR
☐ Huntington's Disease
☐ Other *(call lab to confirm if testing is peformed here):*
____

Information Requested/Reason for Referral

☐ Diagnostic Testing
☐ Predictive testing (*referral to genetics clinic is recommended*)
☐ Carrier status (*family history of this disorder*)
☐ Ship specimen directly to outside laboratory
☐ Bank DNA until further notice
☐ Other: ______________________________

Patient/Family information

Ethnic background ________________________________
□ This individual is the index (first identified) case OR
□ Index Case in Family:
Name ________________________ DOB: ____/___/___
Relationship to this patient _________________________

Pregnancy Information

If this individual or the partner of this individual is currently pregnant:
L.M.P. (YYYY/MM/DD): _______/_____/_____
Amnio (YYYY/MM/DD): _______/_____/_____
CVS (YYYY/MM/DD): _______/_____/_____

Report to: (Physician Information)

Name: ____ Phone (___)__________ FAX: (___)__________

Address: ____ City: _______________ Postal Code: _________

CPSO#: ___________ OHIP Billing #: __________ Signature: ____

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Place Label Here