MICROARRAY REQUISITION

HAMILTON HEALTH SCIENCES

Hamilton Regional Laboratory Medicine Program
Regional Cytogenetics Laboratory, Room 3H45
McMaster University Medical Centre
1200 Main St. W., Hamilton Ontario L8N 3Z5
Office: 3N14 (905) 521-2100 Ext. 73713
Laboratory: 3H45 (905) 521-2100 Ext. 73707

Patient Information

***Name** (print)
Surname, First Name
Address
***DOB** (DD/MM/YY)
***Sex M [ ] F [ ]**
***Health Card No.:**
***Mandatory Information**: (Specimen cannot be processed without this data)

REPORTS TO: Additional Copies to: DATE SAMPLE TAKEN:

Ordering Physician:_____ Name:_____ (DD/MM/YY):
** Surname, First Name **Surname, First Name
Address:_____ Address:_____ Ward/Hospital where sample taken:
**Phone: _____ Fax:_____ **Phone: _____ Fax:_____
Physician Signature:_____ ****Mandatory Information:** (Report cannot be released without this information)

Specimen Submitted*: [ ] Peripheral Blood (**5-10 mL in a sterile EDTA collection tube; 3 mL for neonates/ infants; do not freeze or spin**)
* Contact Lab directly for information regarding submission of other tissues

Sample Information:
[ ] Routine [ ] Expedited
[ ] Follow-up (provide HHS Specimen # or attach external lab report) _____ ___ Relation to proband_____

Clinical Information: Check all that apply. Use additional space at the bottom of the form if needed.

[ ] Prematurity
[ ] Intrauterine growth restriction
[ ] Oligohydramnios /Polyhydramnios
[ ] Non-immune hydrops fetalis
[ ] Other: _____

Growth
[ ] Failure to thrive
[ ] Overgrowth
[ ] Short stature
[ ] Other: _____

Cognitive/Developmental
[ ] Learning disability
[ ] Developmental delay
  [ ] Gross motor delay
  [ ] Fine motor delay
  [ ] Speech delay
[ ] Intellectual disability/MR
[ ] Other: _____

Behavioral/Psychiatric
[ ] Autism
[ ] Pervasive developmental delay
[ ] Attention deficit hyperactivity disorder
[ ] Anxiety
[ ] Schizophrenia
[ ] Other: _____

Cutaneous
[ ] Hyperpigmentation
[ ] Hypopigmentation
[ ] Other: _____

Neurological
[ ] Seizures
[ ] Hypotonia [ ] Hypertonia
[ ] Cerebral palsy
[ ] Encephalopathy
[ ] Structural brain anomaly
Specify: _____
[ ] Other: _____

Cardiac
[ ] Atrial septal defect
[ ] Ventricular septal defect
[ ] Coarctation of the aorta
[ ] Tetralogy of Fallot
[ ] Other cardiac abnormality
Specify: _____

Craniofacial
[ ] Dysmorphic facial features
Specify: _____
[ ] Ear malformation
Specify: _____
[ ] Cleft lip [ ] Cleft palate
[ ] Macrocephaly [ ] Microcephaly
[ ] Other: _____

Hearing/Vision
[ ] Hearing loss
[ ] Abnormality of Vision
[ ] Abnormality of Eye Movement
Specify: _____
[ ] Other: _____

Musculoskeletal
[ ] Contractures
[ ] Club foot
[ ] Diaphragmatic hernia
[ ] Limb/digit anomaly
Specify: _____
[ ] Vertebral anomaly
Specify: _____
[ ] Other: _____

Gastrointestinal
[ ] Gastroschisis
[ ] Omphalocele
[ ] Anal atresia
[ ] Tracheoesophageal fistula
[ ] Pyloric stenosis
[ ] Other: _____

Genitourinary
[ ] Ambiguous genitalia
[ ] Hydronephrosis
[ ] Kidney malformation
Specify: _____
[ ] Cryptorchidism
[ ] Hypospadias
[ ] Other: _____

Family History
[ ] Parents with ≥ 2 miscarriages
[ ] Other relatives with similar clinical history
Explain: _____
_____

Other Relevant Clinical Findings:_____
_____

Known consanguinity (yes/no): specify_____ Isolated population ancestry (yes/no): specify_____
Please Note: This assay can detect regions of homozygosity suggestive of consanguinity. Please check box if information regarding homozygosity is NOT requested. [ ]

LAB USE ONLY
TECH: RECEIVED: LAB NO:
COMMENTS ON SPECIMEN: DNA conc: