Hamilton Health Sciences

Molecular Diagnostic Genetics Requisition

McMaster University Medical Centre
Molecular Genetics Laboratory, Room 2N22
1200 Main Street West, Hamilton, ON L8N 3Z5

Telephone: 905-521-2100 ex.76944
Fax: 905-521-7913
Email: moleculargenetics@hhsc.ca

***Patient Last Name:** ***First Name:**

***DOB (DD/MM/YY)**

***SEX** ❑M ❑F

***Health Card No:**

***Mandatory Information**
(Specimen cannot be processed without this data)

Test Requested:

Please see the HRLMP Laboratory Test Information Guide for complete sample requirements and information http://www.ltig.hrlmp.ca/

❑ Hemoglobinopathy
Ethnicity:_____
- ❑ Thalassemia
- ❑ Hemoglobin Variant
- ❑ Sickle Cell Disease

***CBC, Hemoglobin electrophoresis, and ferritin results are required for processing samples.**

❑ Hemochromatosis (*HFE*)
❑ Metachromatic Leukodystrophy (*ARSA*)
❑ Smith-Lemli-Opitz Syndrome (*DHCR7*)
❑ Medium Chain Acyl-Coenzyme Deficiency (*ACADM*)
❑ Very Long Chain Acyl-Coenzyme Deficiency (*ACADVL*)
❑ Gamma Polymerase Deficiency (*POLG*)
❑ Galactosemia (*GALT*)
❑ Glucose-6-Phosphate Dehydrogenase Deficiency(*G6PD*)
❑ Pyruvate Kinase Deficiency (*PKLR*)
❑ Hyperferritinaemia Cataract Syndrome (*FTL*)
❑ Bank DNA until further notice
❑ Other (Enquire) _____

Specimen Information:

Transport at room temperature to the above address
Date sample taken/location: (DD/MM/YY)_____
❑ Peripheral Blood in EDTA – 5ml
❑ DNA, minimum 6 micrograms Source:_____
❑ Amniotic Fluid, 10-15ml, back-up culture required
❑ Cleaned Chorionic Villi, 5-15mg, back-up culture required
❑ Cultured cells, confluent, 1xT25 flask, back-up culture required

Clinical Indications:

❑ Symptoms of indicated disease
❑ Carrier status
❑ Newborn Screen Positive
❑ Prenatal Diagnosis (provide information below)
- Pregnancy Information
- LMP (DD/MM/YY):_____
- Procedure/Date (DD/MM/YY):_____

❑ Family history (Please provide details below)
- ❑ Index Case **OR**
- Index Case Name:_____
- DOB (DD/MM/YY):_____
- Relationship:_____

PROVIDE A SEPARATE PEDIGREE

❑ Other_____

Expedited Cases are limited to: Prenatal Diagnosis, Newborn Screen Positive, or Patient/Partner Pregnant.

Reports To: **Report will not be sent without complete information!**

*Ordering Physician:
*Address:

*Phone:
*Fax:

*Authorized Signature:_____

Additional Copy to:

Physician:

Address:

Lab Use Only: