AF 708071(01-2004)

Hamilton Health Sciences

Requisition for DNA Testing
Genetics Clinic/MUMC

SEND TO **McMASTER UNIVERSITY MEDICAL CENTRE**
Provincial DNA Diagnostic Laboratory Room 2N22
1200 Main Street West
Hamilton, ON L8N 3Z5

telephone: 905-521-2100 X 76944 fax: 905-521-7913

Patient Last Name: First Name:

Address Number Street

City:

ID Number HIN

Patient's Birthdate (dd/mm/yyyy) Age Sex ❑ M ❑ F

Physician Location

Test Requested

❑ Thalassemia ❑ alpha ❑ beta
❑ Sickle Cell Disease
❑ Hemochromatosis
❑ Metachromatic Leukodystrophy (MLD)
❑ Smith-Lemli-Opitz Syndrome (SLOS)
❑ other _____

Information Requested

❑ Carrier Status
❑ Prenatal Diagnosis
❑ Bank DNA until further notice
❑ other _____

Reason for Referral

❑ Symptoms of indicated disease
❑ Family history of indicated disease
❑ Possible family history of disease
❑ other _____
PROVIDE A SEPARATE PEDIGREE

Family Information

Have samples from this family been sent to a DNA lab before? ❑ yes ❑ no
If yes, specify _____ date sent _____

Individual born in _____ Ethnic background _____

❑ This individual is the index case OR
❑ Name of index case in the family _____ DOB _____

Relationship to this patient _____

Pregnancy Information

LMP (d/m/y) _____

Procedure _____

Procedure _____
date (d/m/y)

Sample Information

Date drawn (d/m/y) _____/_____/_____

Sample Requirements (room temperature)
❑ 10 ml EDTA (lavender top) OR
❑ 10 ml ACD (yellow top)
DO NOT SEND HEPARIN
❑ DNA _____ micrograms
❑ other: please inquire

Prenatal Requirements (room temperature, overnight delivery)
❑ 15 ml amniotic fluid
❑ cultured amniocytes _____ X T25 flask(s)
❑ CVS sample (cleaned) _____ mg (minimum 5 mg)
❑ DNA _____ micrograms

CBC, Hemoglobin electrophoresis, and ferritin results are required for HEMOGLOBINOPATHY samples to be processed

Contact Name and Phone Number

Send report to:

Address:

FAX:

Authorizing Signature_____

Geneticist Printed Name _____ Geneticist Signature _____

Date (day, month, year) _____