

**Kingston Health
Sciences Centre**

Centre des sciences de
la santé de Kingston



Hôpital
Hôtel Dieu
Hospital



Hôpital Général de
Kingston
General
Hospital

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)

Adult -10 cc Pediatric - 3 cc

Cord Blood -10 cc

Prenatal Specimen (notify lab)

Cultured Amniocytes - 2 x T25 Flasks

Cultured CVS - 2 x T25 Flasks

DNA 5-15 µg

Other (specify): _____

Molecular Genetics Tests

Amyloidosis

Factor V Leiden & Prothrombin

MTHFR

Fragile X Syndrome

Hemochromatosis

Huntington's Disease

Hemophilia A or Hemophilia B (complete consent and requisition from <https://www.nibdgl.ca/forms> and send along with this KHSC requisition)

Other (call lab to confirm if testing is performed here): _____

Information Requested/Reason for Referral

Diagnostic Testing

Ship specimen directly to outside laboratory

Predictive testing (referral to genetics clinic is recommended)

Bank DNA until further notice

Carrier status (family history of this disorder)

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: _____

Internal Lab Use Only:

Place Label Here