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

Cytogenetics Laboratory Requisition Form
76 Stuart Street, Douglas 4, Room 8-423
Kingston, ON K7L 2V7
Tel: (613)549-6666 ext. 4219
FAX: (613)548-1356
In-house delivery tube station: 31
http://www.kgh.on.ca/healthcare-providers/lab-requisition-forms

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:** _____

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

SPECIMEN TYPE - ***Keep all specimens at room temperature. Ideally specimen should be received within 24 hours from time of collection.***

☐ Blood (collected in Sodium Heparin) ☐ CVS – *to be sent to Mount Sinai Hospital*

☐ Adult -10 cc ☐ Pediatric -2 cc ☐ Cord Blood -10 cc

☐ Bone marrow (collected in Sodium Heparin) ☐ Solid tissue (specify) _____

☐ Amniotic fluid - please specify below: ☐ Solid tumour: ☐Paraffin Embedded

☐Clear ☐Cloudy ☐Bloody ☐Dark ☐ Other: _____

TEST REQUESTED

☐ Routine chromosome analysis ☐ FISH (specify probe): _____

☐ QF-PCR ☐ Other (specify) _____

ROUTINE ☐ **STAT** ☐ **GESTATION** _____ **weeks**

REASON FOR TESTING: (Specimens will not be analyzed unless adequate information is provided)

CONSTITUTIONAL:	**PRENATAL:**	**ONCOLOGY:**
☐ Developmental delay	☐ AMA	☐ New diagnosis_____
☐ Short stature	☐ Abnormal US (specify)_____	_____
☐ Infertility	☐ Screen positive(specify)_____	☐ Follow-up _____
☐ Multiple miscarriages (≥ 3)	☐ Family history(specify)_____	_____
☐ Other (specify) _____	☐ Other(specify)_____	☐ Other (specify) _____
_____	_____	_____

Please indicate any relevant family members (Name, CR#/Lab#) either tested previously or concurrently within our laboratory:

_____

Report to: (Physician Information)

Name: _____ Phone (___)_____ FAX: (___)_____

Address: _____ City: _____ Postal Code: _____

CPSO#: _____ OHIP Billing #: _____ Signature: _____

Internal Lab Use Only:
Place Label Here