

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

<https://est.omni-assistant.net/kg-h-lab/AutoLogin.aspx?USER=KHSCTESTDIRECTORY>

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

☐ Thrombophilia (Factor V Leiden & Prothrombin)

☐ Fragile X Syndrome

☐ Hemochromatosis

☐ DPYD Genotyping

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

Information Requested/Reason for Referral

☐ Diagnostic Testing

☐ Ship specimen directly to outside laboratory

☐ Carrier status (family history of this disorder)

☐ Bank DNA until further notice

☐ 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: _____

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Place Label Here