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

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: ________________________

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 □ Huntington’s Disease
□ 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: ___________________ DOB: __/__/____

Relationship to this patient ____________________________

If this individual or the partner of this individual is currently pregnant:
L.M.P. (YYYY/MM/DD): _______/_____/_____ 
Ammio (YYYY/MM/DD): _______/_____/_____
CVS (YYYY/MM/DD): _______/_____/_____

Pregnancy Information

Report to: (Physician Information)

Name: ___________________________________________ Phone (___)___________ FAX: (___)___________
Address: _______________________________________ City: _________________ Postal Code: ________
CPSO#: ___________ OHIP Billing #: ___________ Signature: __________________________

Internal Lab Use Only:

Place Label Here

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