Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston
Hôpital Hotel Dieu Hospital | KGH 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)	**Prenatal Specimen (notify lab)**	
☐ Adult -10 cc ☐ Pediatric - 3 cc	☐ Cultured Amniocytes - 2 x T25 Flasks	☐ DNA 5-15 µg
☐ Cord Blood -10 cc	☐ Cultured CVS - 2 x T25 Flasks	☐ 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:

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