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

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)
□ 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

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 □ Family history(specify) ___________
□ Other (specify) ________________  □ Other(specify) ________________  □ Other (specify) _____________

Additional Information:________________________________________________________________________________
_____________________________________________________________________________________________________

Report to: (Physician Information)

Name: ___________________________________________  Phone (____)_________  FAX: (____)_________

Address: ______________________________________  City: ________________  Postal Code: ____________

CPSO#: _________  OHIP Billing #: _________  Signature: ____________________________

Internal Lab Use Only:
Place Label Here