**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

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**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: ________________________**

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**Collection Centre:** __________________________
**Collected by:** __________________________ (please print)
**Date (YYYY/MM/DD): _____/____/____**
**Time:** __________________________

**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:
  - [ ] Clear
  - [ ] Cloudy
  - [ ] Bloody
  - [ ] Dark
- [ ] Solid tumour: [ ] Paraffin Embedded
- [ ] 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:**
- [ ] Developmental delay
- [ ] Short stature
- [ ] Infertility
- [ ] Multiple miscarriages (≥ 3)
- [ ] Other (specify) __________________________

**PRENATAL:**
- [ ] AMA
- [ ] Abnormal US (specify) ____________________________
- [ ] Screen positive (specify) ____________________________
- [ ] Family history (specify) ____________________________
- [ ] Other (specify) ____________________________

**ONCOLOGY:**
- [ ] New diagnosis ____________________________
- [ ] Follow-up ____________________________
- [ ] Other (specify) ____________________________

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

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**Report to:** (Physician Information)

Name: ____________________________ Phone (___)___________ FAX: (___)___________
Address: __________________________ City: __________________________ Postal Code: _________

CPSO#: ____________ OHIP Billing #: ____________ Signature: __________________________

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**Internal Lab Use Only:**

Place Label Here