**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: ________________________**

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### 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

### Molecular Genetics Tests

- □ Amyloidosis  
- □ Factor V Leiden & Prothrombin  
- □ Fragile X Syndrome  
- □ Hemochromatosis  
- □ Hemophilia A  
- □ Hemophilia B  
- □ MTHFR  
- □ Huntington’s Disease  
- □ DNA 5-15 µg  
- □ Other (specify): __________

### Information Requested/Reason for Referral

- □ Diagnostic Testing  
- □ Predictive testing *(referral to genetics clinic is recommended)*  
- □ Carrier status *(family history of this disorder)*  
- □ Other: __________________________

### Patient/Family information

- □ This individual is the index (first identified) case OR  
- □ Index Case in Family:  
  - Name: ___________________________ DOB: ____/___/____
  - Relationship to this patient: __________________________

**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*