SickKids®

Paediatric Laboratory Medicine

Array-Based Comparative Genomic Hybridization

TEST Requisition

CYTOGENETICS LABORATORY (CLIA # 99D1014032)
Black Family Wing, Room 3224
555 University Ave
Toronto ON M5G 1X8 Canada
Tel: (416) 813-7200 x1
Fax: (416) 813-4956

Patient Name
Birthdate (YYYY-MM-DD)
Gender: ☐ Male ☐ Female
Parent's Name
Address

Provincial Health Card #: _____ *Version:* ___
Issuing Province: _____
MRN #:

Complete in full to avoid delay in reporting result.

POSTNATAL aCGH

Specimen Drawn:	Date (YYYY-MM-DD): _____ Time: _____ h (hhmm)
Specimen Type:	❒ Peripheral Blood in EDTA: 3 mL minimum (1 mL minimum for newborns) ❒ Fibroblast Cell Culture: 2xT25 confluent flasks at room temperature
Karyotype *(if known)*:	_____
Indications for Testing:	❒ Developmental delay or mental retardation ❒ Developmental delay or mental retardation in addition to the following clinical features: _____ ❒ Two or more congenital anomalies *(list)*: _____ _____
Family History Relevant family history:	Pedigree (at least 3-generation, when available and if applicable):

Referring Physician	**Copy of Report**
Name: _____	Name: _____
Address: _____	Address: _____
_____	_____
Phone: _____ Fax: _____	Phone: _____ Fax: _____
e-mail: _____	e-mail: _____
Signature *(required):* _____	

Laboratory Use Only: