Northern Regional Genetics Program
Genetics Laboratory
Sudbury Regional Hospital

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Chromosomal Analysis Requisition Form

Sampling date: _____

Name of referring lab: _____

Patient's name: _____ Health Card #: __ __ __ __ - __ __ __ - __ __ __

D.O.B.: DD month YYYY Sex: _____

Address: _____ Parents (if child): _____

City: _____ Postal code: _____ _____ Referring physician: _____

Tissue:

☐ Amniotic Fluid

Reasons for Referral:

☐ Positive screen for trisomy 21
☐ Positive screen for trisomy 18
☐ Positve screen for open neural tube defect
☐ Previous child with chromosomal anomaly. Specify: _____
☐ Wife or ☐ Husband has special karyotype: _____
☐ Mother 35 years or over at delivery
☐ Abnormal ultrasound: _____
☐ X-linked disorder: _____

Ultrasound measurement: _____BPD / _____CRL / ☐ mm ☐ cm / Gestation: ____w____d

☐ Single ☐ Twin ☐ Other:_____ I.D.D.M.: ☐ Yes ☐ No

Race: ☐ Caucasian ☐ Amerindian ☐ Oriental ☐ Black ☐ Asian Indian ☐ Other: _____

20cc must reach laboratory within a day after sampling. Do not freeze. Keep away from heat.

☐ Blood

☐ Suspected chromosomal syndrome:
Specify:_____
_____
☐ Dysmorphic facies (specify): _____
_____
☐ Developmental problem (specify): _____
_____
☐ Mental retardation
☐ Ambiguous genitals (specify): _____
☐ Newborn with three or more major or minor abnormalities (specify below)
☐ Congenital abnormalities:
1. _____ 2. _____ 3. _____
_____
☐ Infertility ☐ Amenorrhea
☐ Patient had 3 or more pregnancy losses (give number): _____
☐ Spouse had 3 or more pregnancy losses. Name of Spouse: _____
☐ Relative with chromosomal abnormality. Specify relationship and abnormality: _____
_____

Microdeletion syndrome:
☐ Angelman
☐ DiGeorge / VCF
☐ Kallmann
☐ Miller-Dieker / Lissencephaly
☐ Prader-Willi
☐ Smith-Magenis
☐ Steroid Sulfatase
☐ Subtelomeres
☐ Williams
☐ Other: _____

Lab method chosen will depend on the information provided and on the blood anti-coagulant.
Collect minimum of 2cc in sodium heparin and 2cc in EDTA. Do not freeze or expose to heat.

☐ CGH Microarray analysis (2cc in EDTA and 2cc in sodium heparin)

☐ Skin or other tissues (specify): _____ **After special arrangement only.**

Collect specimen in Sterile Saline.

Report to: Name: _____
Address: _____
City: _____ Postal Code: _____
Tel: _____ Fax: _____

and to: Name: _____
Address: _____
City: _____ Postal Code: _____
Tel: _____ Fax: _____

GENETICS LAB USE ONLY

Lab Number: _____ Date received: _____

Ped. Number: _____ by: _____