

For PDF Fillable Requisitions, the following applies:

1. The form shall be completed using a Digital Health assigned computer.
2. Absolutely no personal health information shall be electronically saved on a computer.
3. The completed form shall not be shared electronically. If you reasonably believe that e-mailing the information is the only available method of communication or the only way to send the information then you must adhere to the Privacy guideline titled "E-mailing Personal Health Information".
4. All forms must be completed in their entirety, e.g. if a staff member has only completed half of a form they cannot save their work and then come back to complete it at a later date.
5. Once the personal health information has been recorded onto the form, it is to be printed immediately, deleted (not saved) from the computer, and then stored securely inside the client (paper) health record or scanned into an electronic record.
6. Do not print unnecessary duplicate copies of the form.
7. Regular audits of the Digital Health assigned computer shall be undertaken to ensure that no personal health information is being duplicated and saved.

<p>Please have all specimens delivered to: Central Services MS551 820 Sherbrook Street Winnipeg Manitoba R3A 1R9</p>	<p>Additional requisitions / sample requirements at: https://apps.sbgh.mb.ca/labmanual/test/findTestPrepare Cytogenetics Laboratory Health Sciences Centre MS635C 820 Sherbrook St., Winnipeg MB R3A 1R9 Phone 204-787-2489 Fax 204-787-1384</p>	<p><i>Place LIS Sticker Here</i></p>
--	---	--------------------------------------

Acceptance Policy 10-50-03: Requirements for Test Requisitions 2.1 - Fields marked with * or ♦ are mandatory and must be clearly legible or can result in specimen rejection.

CYTOGENETICS & FISH – CONSTITUTIONAL REQUISITION

Ordering Provider Information		Patient Information	
*Last & Full First Name:	Billing Code:	*Last/First Name: (per Health Card)	
*Ordering Facility:		* Date of Birth (dd/mm/yyyy)	
Address:		*Sex: Female Male	
Critical Results Phone Number:	Fax No.:	*PHIN: *Specify if other province/ DND)	
Physician Signature:	Phone No.:	MRN:	
Copy Report To: (if info missing, report may not be sent)			
Last & Full First Name:	Fax No.:	Encounter Number:	
Facility Name/ Address:	Phone No.:	Patient Phone No:	
Last & Full First Name:	Fax No.:	Patient Address:	
Facility Name/ Address:	Phone No.:	Demographics verified: <input type="checkbox"/> Health Card <input type="checkbox"/> Armband <input type="checkbox"/> eChart/CR <input type="checkbox"/> Other	
Collection Information (fields marked with ♦ required by person collecting sample)			
♦ Collector:	♦ Collection Facility/Lab:	♦ Collection Date:	♦ Time:
Sample Type & Requirements - Store at room temperature. DO NOT FREEZE.			
<input type="checkbox"/> Peripheral Blood If pregnant, indicate gestational age: weeks <input type="checkbox"/> Cardiac Blood <input type="checkbox"/> Cord Blood <input type="checkbox"/> DNA (microarray only)			
Test(s) Requested & Indications for Study			
<input type="checkbox"/> ¹ Chromosome Analysis Specimen Collection: 2-4mL in NaHep.			
<input type="checkbox"/> Three or more recognized pregnancy losses (includes miscarriages & stillbirths) <input type="checkbox"/> Infant with suspected Down Syndrome <input type="checkbox"/> Primary or secondary amenorrhea <input type="checkbox"/> Family history of Down Syndrome with unknown status of index case			
<input type="checkbox"/> Infertility <input type="checkbox"/> Suspected Klinefelter Syndrome <input type="checkbox"/> Suspected Turner Syndrome <input type="checkbox"/> Unexplained stillbirth (fetal blood required)			
<input type="checkbox"/> ² Microarray Specimen Collection: 4mL in EDTA <u>and</u> 4mL in NaHep. Infants <1 year of age: 1mL in EDTA <u>and</u> 1mL in NaHep.			
<input type="checkbox"/> Developmental delay/ Intellectual disability <input type="checkbox"/> Multiple congenital anomalies (list in Additional information) <input type="checkbox"/> Dysmorphic features (list in Additional information)			
<input type="checkbox"/> Autism spectrum disorder <input type="checkbox"/> Family studies Proband: <input type="checkbox"/> 22q11.2 targeted array <input type="checkbox"/> Other:			
<input type="checkbox"/> FISH (Clinical Geneticists only) Specimen Collection: 2-4mL in NaHep.			
<input type="checkbox"/> Ambiguous genitalia <input type="checkbox"/> Turner syndrome confirmation <input type="checkbox"/> Sex chromosome mosaicism <input type="checkbox"/> X-linked ichthyosis			
<input type="checkbox"/> Family studies Proband: <input type="checkbox"/> Microarray follow-up <input type="checkbox"/> ³ Other:			
<input type="checkbox"/> Chromosome Breakage Studies (Clinical Geneticists and Hematologists only) Specimen Collection: 2-6mL in NaHep.			
<input type="checkbox"/> Ataxia Telangiectasia <input type="checkbox"/> Fanconi Anemia (Sample must be received by noon, the same day of collection, Monday to Thursday.)			
Additional information:			
¹ Physicians may order chromosome analysis according to the indications listed above, as per guidelines on the LIM. Endocrinologists may order chromosome analysis for sex chromosome disorders. For all other clinical indications require a consult with the clinical geneticist on-call. ² Microarray can only be ordered by a Genetics Professional or developmental pediatrician. 22q11.2 targeted array may be ordered by a pediatric cardiologist or pediatric immunologist. ³ Other constitutional FISH requests may be available for testing by send-out only and are to be discussed with a Cytogeneticist.			<p><i>Genomics LIS Label</i></p>