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.

Please have all specimens delivered to: Central Services MS551 820 Sherbrook Street Winnipeg Manitoba R3A 1R9	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	DELPHIC label

GENOMICS PRENATAL TESTING REQUISITION

Fields marked with * are mandatory and must be clearly legible or can result in specimen rejection

Ordering Provider Information			**Patient Information** *(print or use addressograph)*
*Last & Full First Name:		Billing Code:	*Last/First Name: (per Health Card)
Inpatient Location:	Critical Results Ph #:		*Date of Birth: / / (dd/mm/yyyy)
*Facility Name/ Address:			*Sex: ☐ Female ☐ Male
Ph #:	Fax No.		*PHIN: Specify if other province/ DND
Copy Report To *(if info missing, report may not be sent)*:			MRN:
Last & Full First Name:	Ph:	Fax:	Encounter Number:
Facility Name / Address:			Patient Ph #:
Last & Full First Name:	Ph:	Fax:	Patient Address:
Facility Name / Address:			Demographics verified via: ☐ Health Card ☐ Armband ☐ eChart/CR ☐ Other

Sample Type & Requirements		**Collection Information**
☐ Amniotic Fluid ☐ Other: **Gestational Age: (weeks)** **EDC:**	• 24mL amniotic fluid (**RAD, chromosome analysis or other tests on cultured amniocytes)** • 30mL amniotic fluid (**Microarray or Out of Center testing on direct amniotic fluids)** • Store at room temperature. **DO NOT REFRIGERATE OR FREEZE**.	*Collection Date: / / (dd/ mm/yyyy) *Collection Time: : (hh : mm) Collected By:

Test(s) Requested (GENO)

☐ **Chromosome Analysis**

☐ **FISH** (select probe from list)
- ☐ Xp22.3 STS/CEPX
- ☐ 22q11.2 HIRA (refer to testing criteria in LIM)
- ☐ Other FISH request: _____

Requires lab pre-approval

☐ **Microarray** *(Genetics Professional only)*
Maternal Sample Required. Submit with R250-10-09.
- ☐ Direct amniotic fluid
- ☐ Cultured amniocytes
- ☐ Targeted familial array (Additional information required)

Biochemical Out of Center test request *(separate requisition required)*
- ☐ Smith-Lemli Opitz (SLOS, 7-DHC (*protect from light)*
- ☐ Acetylcholinesterase (ACHE)

Other Test Request: _____

☐ **Rapid Aneuploidy Detection (RAD)**

☐ **[1]Direct amniotic fluid for molecular testing**
- ☐ In-house Test (specify): _____
- ☐ Molecular Out of Center test request (specify):_____

(R250-10-103 requisition to follow)

Volume for Send-out testing: _____
- ☐ DNA from direct amniotic fluid

☐ **[1]Cultured amniocytes for molecular testing**
- ☐ DNA banking
- ☐ In-house Test (specify): _____
- ☐ Molecular Out of Center test request (specify):_____

(R250-10-103 requisition to follow)
- ☐ DNA ☐ T25 Flask

[1]Consultation with Lab GC for sample requirements is required.

Indication for Testing	**Additional Information**
☐ Positive maternal serum screen *(specify)*: ☐ Positive NIPT – Specify result and fetal sex: *Maternal Sample Required. Submit with R250-10-09.* ☐ Previous or known familial chromosome abnormality or mutation carrier ☐ Known familial gene variant(s) ☐ Abnormality seen on ultrasound ☐ Cardiac anomaly ☐ Cystic hygroma ☐ Neural tube defect ☐ Nuchal translucency ☐ Other abnormalities: ☐ Other Indication:	Proband name: Proband DOB: / / (dd/mmm/yyyy) Relationship: CNV(s) (*specify*): Family History & Clinical Information: *Genomics LIS Label*