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

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 – PRENATAL REQUISITION

| ORDERING PROVIDER INFORMATION | | | |
|---|---|---|---|
| *Last & Full First Name: | | Billing Code: | |
| *Ordering Facility: | | Inpatient Location: | |
| Address: | | | |
| Critical Results Phone No: | *Fax No. | | |

| ADDITIONAL COPY OF REPORT IF REQUIRED | | | |
|---|---|---|---|
| *Last & Full First Name: | | Billing Code: | |
| *Facility Name: | | | |
| Address: | | | |
| Phone No: | | *Fax No. | |

**PATIENT INFORMATION**

*Last/First Name:
(as per Manitoba Health Card)
*Date of Birth: / /
(dd / mm/ yyyy)
*Sex: ☐ Female ☐ Male

*PHIN:
Specify if other province/ DND
MRN:

Encounter Number:

Patient Phone No.:

Patient Address:

Demographics verified with: ☐ Health Card ☐ eChart/CR ☐ Armband

**SAMPLE TYPE & REQUIREMENTS**

☐ Amniotic Fluid

☐ Other:

**Gestational Age:** **weeks**

**For QF-PCR, chromosome analysis or other tests on cultured amniocytes:** 24mL amniotic fluid required.

#**Send-out testing for direct amniotic fluids:** 30mL amniotic fluid required.

**SLOS (7-DHC):** 24mL amniotic fluid required. *Protect sample from light.*

Store at room temperature. DO NOT FREEZE.

**COLLECTION INFORMATION**

*Collection Date: / /
(dd/ mm/ yyyy)

*Collection Time: :
(hh : mm)

Collected By:

**TEST(S) REQUESTED**

☐ QF-PCR

☐ Chromosome Analysis

☐ FISH (select probe from list)
*(Clinical Geneticists only)*

☐ #Direct Amniotic Fluid for Molecular Diagnostics
*(Molecular Diagnostics requisition required)*

☐ Cultured Amniocytes for Molecular Diagnostics
*(Molecular Diagnostics requisition required)*
- ☐ DNA banking
- ☐ In-house Test
- ☐ Send Out Test

☐ #Microarray on Direct Fluid
*(Genetics Professional only)*

☐ Microarray on Cultured Amniocytes
*(Genetics Professional only)*

☐ Smith-Lemli Opitz (SLOS, 7-DHC)
*(separate requisition required)*

☐ Acetylcholinesterase (ACHE)
*(separate requisition required)*

**INDICATION FOR STUDY**

☐ Positive maternal serum screen

☐ Positive NIPT Specify result:

☐ Abnormality seen on ultrasound
- ☐ Nuchal translucency
- ☐ Cystic hygroma
- ☐ Cardiac anomaly
- ☐ Neural tube defect

☐ Other:

☐ Known familial/previous chromosome abnormality

☐ Parent known mutation carrier

☐ Other:

Additional information:

**FISH PROBE LIST:**

☐ CEPX/CEPY

☐ Xp22.3 STS/CEPX

☐ [1]22q11.2 HIRA

☐ †Other:

[1]*Please see 22q11.2 FISH Criteria on the LIM.*

†*Other amniotic fluid FISH requests may be available for testing by send-out only and are to be discussed with a Cytogeneticist.*

**CYTOGENETICS LAB USE ONLY**

Computer Code: _____ Status Code: _____

Laboratory No.: _____ Date Sample Received: _____

*Genomics LIS Label*