

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.

<b><u>Please have all specimens delivered to:</u></b> Central Services MS551 820 Sherbrook Street Winnipeg Manitoba R3A 1R9	Additional requisitions / sample requirements at: <a href="https://apps.sbgf.mb.ca/labmanual/test/findTestPrepare">https://apps.sbgf.mb.ca/labmanual/test/findTestPrepare</a> Cytogenetics Laboratory Health Sciences Centre MS635C 820 Sherbrook St., Winnipeg MB R3A 1R9 Phone 204-787-2489 Fax 204-787-1384	<b>DELPHIC label</b>
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## 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: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Ph #:	Fax No.	*PHIN: Specify if other province/ DND	
<b>Copy Report To (if info missing, report may not be sent):</b>		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:		
<input type="checkbox"/> Health Card <input type="checkbox"/> Armband <input type="checkbox"/> eChart/CR <input type="checkbox"/> Other			
Sample Type & Requirements		Collection Information	
<input type="checkbox"/> Amniotic Fluid <input type="checkbox"/> Other: <b>Gestational Age: (weeks)</b> <b>EDC:</b>	<ul style="list-style-type: none"> <li>24mL amniotic fluid (<b>RAD, chromosome analysis or other tests on cultured amniocytes</b>)</li> <li>30mL amniotic fluid (<b>Microarray or Out of Center testing on direct amniotic fluids</b>)</li> <li>Store at room temperature. <b>DO NOT REFRIGERATE OR FREEZE.</b></li> </ul>		*Collection Date:    /    /    (dd/ mm/yyyy) *Collection Time:    :    (hh : mm) Collected By:
Test(s) Requested (GENO)			
<input type="checkbox"/> <b>Chromosome Analysis</b> <input type="checkbox"/> <b>FISH</b> (select probe from list) <input type="checkbox"/> Xp22.3 STS/CEPX <input type="checkbox"/> 22q11.2 HIRA (refer to testing criteria in LIM) <input type="checkbox"/> Other FISH request: _____ <i>Requires lab pre-approval</i> <input type="checkbox"/> <b>Microarray (Genetics Professional only)</b> <i>Maternal Sample Required. Submit with R250-10-09.</i> <input type="checkbox"/> Direct amniotic fluid <input type="checkbox"/> Cultured amniocytes <input type="checkbox"/> Targeted familial array (Additional information required) <b>Biochemical Out of Center test request (separate requisition required)</b> <input type="checkbox"/> Smith-Lemli Opitz (SLOS, 7-DHC ( <i>protect from light</i> )) <input type="checkbox"/> Acetylcholinesterase (ACHE) <b>Other Test Request:</b> _____		<input type="checkbox"/> <b>Rapid Aneuploidy Detection (RAD)</b> <input type="checkbox"/> <b>1Direct amniotic fluid for molecular testing</b> <input type="checkbox"/> In-house Test (specify): _____ <input type="checkbox"/> Molecular Out of Center test request (specify): _____ <i>(R250-10-103 requisition to follow)</i> Volume for Send-out testing: _____ <input type="checkbox"/> DNA from direct amniotic fluid <input type="checkbox"/> <b>1Cultured amniocytes for molecular testing</b> <input type="checkbox"/> DNA banking <input type="checkbox"/> In-house Test (specify): _____ <input type="checkbox"/> Molecular Out of Center test request (specify): _____ <i>(R250-10-103 requisition to follow)</i> <input type="checkbox"/> DNA <input type="checkbox"/> T25 Flask  <b>1Consultation with Lab GC for sample requirements is required.</b>	
Indication for Testing		Additional Information	
<input type="checkbox"/> Positive maternal serum screen ( <i>specify</i> ): <input type="checkbox"/> Positive NIPT – Specify result and fetal sex: <i>Maternal Sample Required. Submit with R250-10-09.</i> <input type="checkbox"/> Previous or known familial chromosome abnormality or mutation carrier <input type="checkbox"/> Known familial gene variant(s) <input type="checkbox"/> Abnormality seen on ultrasound <input type="checkbox"/> Cardiac anomaly <input type="checkbox"/> Cystic hygroma <input type="checkbox"/> Neural tube defect <input type="checkbox"/> Nuchal translucency <input type="checkbox"/> Other abnormalities: <input type="checkbox"/> Other Indication:		Proband name: Proband DOB:    /    /    (dd/mm/yyyy)    Relationship: CNV(s) ( <i>specify</i> ): Family History & Clinical Information:	
		<div style="border: 1px solid black; padding: 5px; text-align: center;"> <b>Genomics LIS Label</b> </div>	