

MOLECULAR GENETICS REQUISITION

Core Molecular Diagnostic Laboratory (CMDL)
1001 Decarie boul., E05.5051, Montreal, QC, H4A 3J1
Email: molecular.genetics@muhc.mcgill.ca
Tel: 514-934-1934 x23383 / x23298
Fax: 514-938-7405

Referring Physician:*

Name (Last, First):*

License #:* Institution:*

Address:*

E-mail address:*

Tel:* Fax:*

(Fax # to send results)

Genetic counsellor/Nurse:

Tel: Fax:

I acknowledge that the patient/guardian is aware of the benefits, limitations and risks associated with the requested test(s) and that I have obtained informed consent to perform genetic testing for this patient. I authorize the laboratory to fax results to the number provided above.

Signature:* Date:*/*/

Sample Information:*

Collection Date – Time:*/*/ at h min

Collected by (Last, First):*

2 x 4 mL blood in EDTA tubes (purple top tube) – 2 mL for newborns

DNA: min 10 µg – Source:

Amniotic fluid: min 10 mL

Cultured amniocytes: 2 x T25 flasks (confluent)

Direct CVS: min 10 mg direct villi

Cultured CVS: 2 x T25 flasks (confluent)

Tissue – Specify:

Other – Specify:

Please check our test directory for test-specific requirements:
<https://muhc.ca/health-professionals-and-teaching/muhc-clinical-laboratories>

CMDL - Laboratory use only:

Date – Time received:

/ /

h min

SAMPLE LABEL(S) HERE

Sample type and # of tubes:

Patient #:

Family #:

Name (Last, First):*

Birth date (YYYY-MM-DD):* / /

Father's name:

Mother's name:

Medical Record # (MRN):*

RAMQ #:*

For babies, please provide mother's RAMQ #

Sex: Male Female Unknown

Test Requested:*

(Write below OR check boxes on page 2 if more than one test is requested)

Reason for Testing:*

Diagnostic testing (*affected case*)

Carrier testing (*unaffected case – for recessive conditions*)

Predictive testing (*unaffected case – for dominant conditions*)

Prenatal testing (*maternal sample required*)

Drug response (*pharmacogenetics*)

Other – Specify:

Reason for expedited testing (if applicable):

Pregnancy (Gestational age: weeks on / /)

Other reason – Specify:

Familial Variant Testing:

Please attach a copy of the proband's report. If the familial variant was not previously tested at the CMDL, please provide a sample from a family member known to be positive for this variant (i.e. a positive familial control).

Gene (HGNC symbol):

Variant(s) (HGVS format):

CMDL Family #:

Name of proband:

Relationship to proband:

Pedigree / Clinical Information:

Please draw or attach pedigree and provide relevant clinical information.

Ethnicity:*

Ordering Checklist:*

Specimen tubes labelled with at least two identifiers*

Completed test requisition (this form)*

Completed test eligibility criteria form or information sheet (if applicable)

Consent form

***Required information. Samples will not be processed if information is missing.**

CMDL - Laboratory use only:

Date – Time received:

____ / ____ / ____
____ h ____ min

SAMPLE LABEL(S) HERE

Sample type and # of tubes:

Patient #:

Family #:

PATIENT STAMP OR LABEL HERE

Name (Last, First):*

Birth date (YYYY-MM-DD):* / /

Father's name:

Mother's name:

Medical Record # (MRN):*

RAMQ #:*

For babies, please provide mother's RAMQ #

Sex:* Male Female Unknown

LIST OF TESTS & DISEASES

Please use this page ONLY if more than one test is requested.

For prenatal testing and analysis of familial variants, please provide information on page 1 (Familial Variant Testing section).

Alpha-1-antitrypsin deficiency

SERPINA1 genotyping

Amyotrophic lateral sclerosis (ALS)

ALS panel (SOD1, FUS, TARDBP, C9ORF72, ATXN2)

C9ORF72 repeat expansion

ATXN2 repeat expansion

Angelman / Prader-Willi syndrome: Angelman Prader-Willi

Methylation and deletion/duplication analysis

Uniparental disomy of chromosome 15 (parental samples required)

Ashkenazi Jewish carrier screening

ASPA, ELP1, HEXA sequencing (Canavan disease, familial dysautonomia, Tay-Sachs disease)

Canavan disease

ASPA sequencing

Cancer predisposition syndrome

Hereditary cancer predisposition syndrome panel *

Pediatric hereditary cancer panel (CQGC)*

Cancer predisposition single-gene sequencing – Specify:

_____ (Medical Genetics only)

Cystic fibrosis and CFTR-related disorders

CFTR sequencing

Familial dysautonomia

ELP1 sequencing

HBB-related hemoglobinopathies

Phenotype: HbS HbC HbE Other: _____
β-thalassemia: Major Intermedia Trait/Minor

HBB sequencing

Hereditary dyslipidemia

APOE genotyping (dysbetalipoproteinemia)

LDLR, APOB, PCSK9 sequencing (familial hypercholesterolemia)

Hereditary hemochromatosis

HFE genotyping

Hexosaminidase A deficiency (Tay-Sachs disease)

HEXA sequencing

Hidrotic ectodermal dysplasia (Clouston syndrome)

GJB6 sequencing

Huntington disease

HTT repeat expansion

Male infertility

Y-chromosome microdeletion analysis

MCAD deficiency

ACADM sequencing

Methylmalonic acidemia

MMACHC sequencing

Nonsyndromic hearing loss

Nonsyndromic hearing loss panel (CQGC)*

PAH deficiency: PKU Hyperphenylalaninemia

PAH sequencing

Pharmacogenetics

DPYD genotyping

Postnatal aneuploidy

QF-PCR (chromosomes 13, 18, 21, X, Y)

For MUHC (Glen) only

Bank DNA (Medical Genetics only)

Bank RNA (Medical Genetics only)

Microsatellite (STR) analysis:

Maternal cell contamination analysis (maternal sample required)

Zygosity analysis

Specimen matching analysis

Other test – Specify: _____

(Please contact us first for information)

***Test with a required eligibility criteria form or clinical information sheet**