



POSTNATAL CHROMOSOMAL SNP MICROARRAY

COMPLETE IN FULL TO AVOID DELAY IN REPORTING RESULTS

PRESCRIBER	Patient identification
Last & First name : _____ No. License : _____ Signature : _____ Date : (YYYY/MM/DD) _____ Site, Clinic, Office : _____ Address for return of results : _____ _____ No. telephone : _____ Report copy to : _____ No. License : _____	Last name : _____ First name : _____ MRN or RAMQ : _____ Address : _____ Date of birth (YYYY/MM/DD) : _____ Gender : _____

SPECIMEN TYPE :	<input type="checkbox"/> Peripheral Blood in EDTA (purple cap): 3mL minimum (1 mL minimum for newborns) <input type="checkbox"/> Tissue: _____ <input type="checkbox"/> Other: _____ (requires consult with Cytogeneticist)
SAMPLING :	Date (YYYY/MM/DD) : _____ Time : _____
TESTED INDIVIDUAL:	<input type="checkbox"/> Proband <input type="checkbox"/> Relative of proband : _____ Phenotype : <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Proband' name and report number: _____ _____ _____
INDICATIONS FOR TESTING:	<input type="checkbox"/> Developmental delay or intellectual disability <input type="checkbox"/> Developmental delay or intellectual disability and additional clinical features (complete page 2). <input type="checkbox"/> Congenital anomalies (complete page 2).

PRENATAL, PERINATAL AND FAMILY HISTORY

Ethnicity _____ Parents with ≥ 3 miscarriages Consanguinity

List health conditions found prenatally, perinatally, in family (describe the relationship with proband) and any additional pertinent information

Pedigree (at least 3-generation, when available and if applicable):

PHENOTYPIC DESCRIPTION (CLINICAL SYMPTOMS)

BEHAVIOR/ COGNITION/ DEVELOPMENT

- Global developmental delay
 - Gross motor delay
 - Fine motor delay
 - Language delay
 - Learning disability
 - Intellectual disability
 - Mild
 - Moderate
 - Severe
 - Attention deficit hyperactivity disorder
 - Autism Spectrum Disorder
 - Psychiatric disorder (Specify)
- _____
- _____
- _____

Other : _____

NEUROLOGICAL

- Hypotonia
 - Seizures
 - Ataxia
 - Dystonia
 - Chorea
 - Spasticity
 - Cerebral palsy
 - Neural tube defect
 - CNS abnormality (Specify)
- _____

Other: _____

GROWTH PARAMETERS

Weight for age:

- <3rd %
- >97th %

Stature for age:

- <3rd %
- >97th %

Head circumference:

- <3rd %
- >97th %

Hemihypertrophy

Other: _____

CARDIAC

- ASD
 - VSD
 - AV canal defect
 - Coarctation of aorta
 - Tetralogy of Fallot
 - Other: _____
- _____

CRANIOFACIAL

- Craniosynostosis
 - Cleft lip
 - Cleft palate
 - Micrognathia
 - Retrognathia
 - Facial dysmorphism (Specify)
- _____

Other: _____

EYE DEFECTS

- Blindness
 - Coloboma
 - Epicanthus
 - Hypertelorism
 - Eyelid abnormality (Specify)
- _____

Other: _____

EAR DEFECTS

- Deafness
 - Preauricular: Pit Skin Tag
 - Low-set ears
 - Outer ear abnormality (Specify)
- _____

Inner ear abnormality (Specify)

Other: _____

CUTANEOUS

- Hyperpigmentation
 - Hypopigmentation
 - Other: _____
- _____

RESPIRATORY

- Diaphragmatic hernia
 - Lung abnormality (Specify)
- _____
- _____
- Other: _____

MUSCULOSKELETAL

- Upper limb abnormality
 - Lower limb abnormality
 - Camptodactyly (finger / toe)
 - Syndactyly (fingers / toes)
 - Polydactyly (finger / toe
 - Preaxial
 - Postaxial
 - Oligodactyly (finger / toe)
 - Clinodactyly (finger / toe)
 - Contractures
 - Scoliosis
 - Vertebral anomaly
 - Club foot
 - Other: _____
- _____
- _____

GASTROINTESTINAL

- Esophageal atresia
 - Tracheoesophageal fistula
 - Gastroschisis
 - Omphalocele
 - Pyloric stenosis
 - Other: _____
- _____

GENITOURINARY

- Kidney malformation (Specify)
- _____
- _____
- Hydronephrosis
 - Ambiguous genitalia
 - Hypospadias
 - Cryptorchidism
 - Other: _____
- _____

THIS REQUISITION MUST BE ACCOMPANIED BY A SIGNED INFORMED CONSENT
available at <https://muhc.ca/muhc-clinical-laboratories/muhc-laboratory-requisitions-and-consultations>