



MOLECULAR GENETICS REQUISITION

Core Molecular Diagnostic Laboratory (CMDL)

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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 #:

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

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 *☐ Cancer predisposition single-gene sequencing – Specify:

(Medical Genetics only)

Cystic fibrosis and CFTR-related disorders☐ CFTR sequencing**Familial dysautonomia**☐ ELP1 sequencing**Familial Mediterranean fever**☐ MEFV 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**☐ DFNB1 panel (GJB2, GJB6 sequencing)**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**