OPTILAB Montréal-CUSM

Centre universitaire de santé McGill — McGill University Health Centre

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

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

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:* / /

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:

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-professionnals-and-teaching/muhc-clinical-laboratories

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:*

CMDL - Laboratory use only:

Date – Time received:

/ /

h min

SAMPLE LABEL(S) HERE

Sample type and # of tubes:

Patient #:

Family #:

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

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
☐ 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**