Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

Cytogenetics Laboratory
Test Requisition

76 Stuart Street, Douglas 4, Room 8-423
Kingston, ON K7L 2V7
Tel: (613)549-6666 ext. 64219
FAX: (613)548-1356
In-house delivery tube station: 31
https://est.omni-assistant.net/kgh-lab/AutoLogin.aspx?USER=KHSCTESTDIRECTORY

Internal Lab Use Only

CR# or Hospital ID #: ____________________

Patient Name: ____
(Last) (First)

Date of Birth (YYYY/MM/DD):_______/_____/_____ **Sex: M/F**

Health Card #:__________________________**Expiry Date:** __________

Address: ____

Postal Code:_______________ **Phone:** ______________________

Collection Centre:___________________________ Collected by:__________________________(please print)

Date (YYYY/MM/DD):_________/____/____ Time:___________ ☐Collected at Room Temperature

Note: The requisition and specimen must carry the same two unique patient identifiers or the sample may be rejected

SPECIMEN TYPE - ***Keep all specimens at room temperature. Ideally specimen should be received within 24 hours from time of collection.***

☐ Blood (collected in Sodium Heparin)
☐ Adult -10 cc ☐ Pediatric -2 cc ☐ Cord Blood -10 cc

☐ Blood (2 cc collected in EDTA) for Rapid Aneuploidy Detection (RAD)

☐ Bone marrow (collected in Sodium Heparin)

☐ Solid tissue (specify) _____________________________
(provide additional tissue material if multiple tests requested)

☐ Amniotic fluid - please specify below:
☐Clear ☐Cloudy ☐Bloody ☐Dark

☐ Solid tumour: ☐Paraffin Embedded -Internal Surgical Number:_________
-External Surgical Number:________

TEST REQUESTED

☐ Routine chromosome analysis

☐ Rapid Aneuploidy Detection (RAD) - (check appropriate sample type above)

☐ FISH (specify probe): ___________________________

☐ Other (specify) ________________________________

ROUTINE ☐ **STAT** ☐ **GESTATION**_______________________**weeks**

REASON FOR TESTING: (Specimens will not be analyzed unless adequate information is provided)

CONSTITUTIONAL:

☐ Developmental delay
☐ Short stature
☐ Infertility
☐ Multiple miscarriages (≥ 3)
☐ Other (specify)________________
____

PRENATAL:

☐ AMA
☐ Abnormal US (specify)____________
☐ Screen positive(specify)___________
☐ Family history(specify)____________
☐ Other(specify)_________________
____

ONCOLOGY:

☐ New diagnosis________________
____
☐ Follow-up __________________
____
☐ Other (specify) ______________
____

Please indicate any relevant family members (Name, CR#/Lab#) either tested previously or concurrently within our laboratory:

____

Report to: (Physician Information)

Name:____Phone (_____)__________FAX: (_)____________

Address:____City:__________________ Postal Code: _________

CPSO#:____________ OHIP Billing #:___________Signature: ____

Internal Lab Use Only:
Place Label Here