

**Kingston Health  
Sciences Centre**

Centre des sciences de  
la santé de Kingston



Hôpital  
Hôtel Dieu  
Hospital



Hôpital Général de  
Kingston  
General  
Hospital

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: \_\_\_\_\_

**Molecular Genetics Laboratory  
Requisition**

76 Stuart Street, Douglas 4, Room 8-415

Kingston, ON K7L 2V7

Tel: (613)549-6666 ext. 64892

FAX: 613-548-1356

In-house delivery tube station: #31

<https://est.omni-assistant.net/kg-h-lab/AutoLogin.aspx?USER=KHSCTESTDIRECTORY>

**Specimen Requirements**

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*

**Blood (EDTA -Lavender or Pink )**

Adult -10 cc  Pediatric -3 cc

Cord Blood -10 cc

**Prenatal Specimen (notify lab )**

Cultured Amniocytes - 2 x T25 Flasks

Cultured CVS - 2 x T25 Flasks

DNA 5-15 µg

Other (specify): \_\_\_\_\_

**Molecular Genetics Tests**

Amyloidosis

Thrombophilia (Factor V Leiden & Prothrombin)

Fragile X Syndrome

Hemochromatosis

DPYD Genotyping

Other (call lab to confirm if testing is performed): \_\_\_\_\_

*Additional requests (internal KHSC clinicians only):*

Bank DNA until further notice

Ship specimen directly to outside laboratory \_\_\_\_\_

**Information Requested/Reason for Referral**

Diagnostic Testing

Other: \_\_\_\_\_

Carrier status (family history of this disorder)

**Patient/Family information**

Ethnic background \_\_\_\_\_

This individual is the index (first identified) case OR

Index Case in Family:

Name \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship to this patient: \_\_\_\_\_

**Pregnancy Information**

**If this individual or the partner of this individual is currently pregnant:**

L.M.P. (YYYY/MM/DD): \_\_\_\_/\_\_\_\_/\_\_\_\_

Amnio (YYYY/MM/DD): \_\_\_\_/\_\_\_\_/\_\_\_\_

CVS (YYYY/MM/DD): \_\_\_\_/\_\_\_\_/\_\_\_\_

**Report to: (Physician Information)**

Name: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ FAX: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

CPSO#: \_\_\_\_\_ OHIP Billing #: \_\_\_\_\_ Signature: \_\_\_\_\_

**Internal Lab Use Only:**

Place Label Here