

Chromosome Microarray and Follow-Up Test Requisition

PATIENT INFORMATION

Name: Address:

Birthdate (yyyy/mm/dd): City: Province: Postal Code:

Sex: M F Unknown Unspecified Health Card Number: Version:

Birthsex: M F Unknown Unspecified

Complete in full to avoid delay in result reporting

PHYSICIAN INFORMATION

Referring Doctor:

Registration Number:

Address:

Telephone: Fax:

Signature (required):

Copy to:

Registration Number:

Address:

Telephone: Fax:

SPECIMEN COLLECTION For sample collection please visit local blood draw centre

Date: Time:

Microarray Testing	<input checked="" type="checkbox"/> Chromosome Microarray Peripheral Blood in EDTA (purple top tube) or <input type="checkbox"/> DNA (MD#: <input type="text"/>)
Targeted Microarray	<input type="checkbox"/> Microdeletion Syndromes Peripheral Blood in EDTA (purple top tube) <input type="checkbox"/> DiGeorge / VCF <input type="checkbox"/> Williams
Follow-Up Study	<input type="checkbox"/> Targeted Microarray, FISH, and/or Chromosome Analysis Peripheral Blood in NaHep (dark green top tube, 3 mL min. per individual, 1 mL min. for newborns) Index case name: <input type="text"/> GA Number: <input type="text"/> Relationship to proband: <input type="text"/> Symptomatic: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, please fill in symptoms on page 2)</i> <i>If testing was done by an outside lab, please attach a copy of the report.</i>
Indications for Testing	<input checked="" type="checkbox"/> Developmental Delay or Intellectual Disability <input type="checkbox"/> Developmental Delay or Intellectual Disability and additional clinical features <i>(Complete Clinical Description Form page 2)</i> <input type="checkbox"/> Two or more congenital anomalies <i>(Complete Clinical Description Form page 2)</i>
Relevant Family History	Pedigree (at least 3-generations, indicate consanguinity when/if applicable) <input type="checkbox"/> Parents with ≥ 3 miscarriages <input type="checkbox"/> Consanguinity <input type="checkbox"/> List health conditions found in family (describe relationship to proband): <input type="text"/>
Copy Number Variant Reinterpretation Request	<input type="checkbox"/> Reinterpretation of previously reported copy number variant. <i>No new specimen required. Fax requisition directly.</i> Index case name: <input type="text"/> GA Number: <input type="text"/> New Clinical Information: <input type="text"/> <i>Reanalysis requests should be sent to the original reporting lab.</i> <i>We will not be able to re-analyze variants detected by other centres.</i>

SHIPPING ADDRESS (For sample collection please visit local blood draw centre)

Cytogenetics Laboratory
 Victoria Hospital, Room B10-114
 800 Commissioners Rd. E.
 London, ON | N6A 5W9
 Ph: 519-685-8500 x 78974 | Fax: 519-667-6720

CLINICAL DESCRIPTION (PRINT CLEARLY)

<p>Behaviour, Cognition and Development</p> <p><input checked="" type="checkbox"/> Global development delay</p> <p><input type="checkbox"/> Gross motor delay</p> <p><input type="checkbox"/> Fine motor delay</p> <p><input type="checkbox"/> Language delay</p> <p><input type="checkbox"/> Learning disability</p> <p><input type="checkbox"/> Intellectual disability:</p> <p style="margin-left: 20px;"><input type="checkbox"/> Mild</p> <p style="margin-left: 20px;"><input type="checkbox"/> Moderate</p> <p style="margin-left: 20px;"><input type="checkbox"/> Severe</p> <p><input type="checkbox"/> Attention deficit hyperactivity disorder</p> <p><input checked="" type="checkbox"/> Autism Spectrum Disorder</p> <p><input type="checkbox"/> Psychiatric disorders (specify below):</p> <p style="margin-left: 20px;"><input type="text"/></p> <p><input type="checkbox"/> Other: <input type="text"/></p> <p>Neurological</p> <p><input type="checkbox"/> Hypotonia</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Ataxia</p> <p><input type="checkbox"/> Dystonia</p> <p><input type="checkbox"/> Chorea</p> <p><input type="checkbox"/> Spasticity</p> <p><input type="checkbox"/> Cerebral palsy</p> <p><input type="checkbox"/> Neural tube defect</p> <p><input type="checkbox"/> Abnormality of the CNS (specify below):</p> <p style="margin-left: 20px;"><input type="text"/></p> <p><input type="checkbox"/> Other: <input type="text"/></p> <p>Growth Parameters</p> <p>Weight for age: <input type="checkbox"/> <3rd% <input type="checkbox"/> >97th%</p> <p>Stature for age: <input type="checkbox"/> <3rd% <input type="checkbox"/> >97th%</p> <p>Head circumference: <input type="checkbox"/> <3rd% <input type="checkbox"/> >97th%</p> <p><input type="checkbox"/> Hemihypertrophy</p> <p><input type="checkbox"/> Other: <input type="text"/></p>	<p>Cardiac</p> <p><input type="checkbox"/> ASD</p> <p><input type="checkbox"/> VSD</p> <p><input type="checkbox"/> AV canal defect</p> <p><input type="checkbox"/> Coarctation of aorta</p> <p><input type="checkbox"/> Tetralogy of fallot</p> <p><input type="checkbox"/> Other: <input type="text"/></p> <p>Craniofacial</p> <p><input type="checkbox"/> Craniosynostosis</p> <p><input type="checkbox"/> Cleft lip <input type="checkbox"/> Cleft palate</p> <p><input type="checkbox"/> Micrognathia <input type="checkbox"/> Retrognathia</p> <p><input type="checkbox"/> Facial dysmorphism (specify below):</p> <p style="margin-left: 20px;"><input type="text"/></p> <p><input type="checkbox"/> Other: <input type="text"/></p> <p>Eye Defects</p> <p><input type="checkbox"/> Blindness</p> <p><input type="checkbox"/> Coloboma</p> <p><input type="checkbox"/> Epicanthus</p> <p><input type="checkbox"/> Hypertelorism</p> <p><input type="checkbox"/> Eyelid abnormality (specify below):</p> <p style="margin-left: 20px;"><input type="text"/></p> <p><input type="checkbox"/> Other: <input type="text"/></p> <p>Ear Defects</p> <p><input type="checkbox"/> Deafness</p> <p><input type="checkbox"/> Preauricular <input type="checkbox"/> Pit <input type="checkbox"/> Skin tag</p> <p><input type="checkbox"/> Low-set ears</p> <p><input type="checkbox"/> Outer ear abnormality (specify below):</p> <p style="margin-left: 20px;"><input type="text"/></p> <p><input type="checkbox"/> Inner ear abnormality <i>oh jes</i>:</p> <p style="margin-left: 20px;"><input type="text"/></p> <p><input type="checkbox"/> Other: <input type="text"/></p> <p>Cutaneous</p> <p><input type="checkbox"/> Hyperpigmentation</p> <p><input type="checkbox"/> Hypopigmentation</p> <p><input type="checkbox"/> Other: <input type="text"/></p>	<p>Respiratory</p> <p><input type="checkbox"/> Diaphragmatic hernia</p> <p><input type="checkbox"/> Lung abnormality (specify below):</p> <p style="margin-left: 20px;"><input type="text"/></p> <p><input type="checkbox"/> Other: <input type="text"/></p> <p>Musculoskeletal</p> <p><input type="checkbox"/> Upper limb abnormality</p> <p><input type="checkbox"/> Lower limb abnormality</p> <p><input type="checkbox"/> Camptodactyly <input type="checkbox"/> Finger/ <input type="checkbox"/> Toe</p> <p><input type="checkbox"/> Syndactyly <input type="checkbox"/> Fingers/ <input type="checkbox"/> Toes</p> <p><input type="checkbox"/> Polydactyly <input type="checkbox"/> Fingers/ <input type="checkbox"/> Toes</p> <p style="margin-left: 20px;"><input type="checkbox"/> Preaxial</p> <p style="margin-left: 20px;"><input type="checkbox"/> Postaxial</p> <p><input type="checkbox"/> Oligodactyly <input type="checkbox"/> Finger/ <input type="checkbox"/> Toe</p> <p><input type="checkbox"/> Clinodactyly <input type="checkbox"/> Finger/ <input type="checkbox"/> Toe</p> <p><input type="checkbox"/> Contractures</p> <p><input type="checkbox"/> Scoliosis</p> <p><input type="checkbox"/> Vertebral anomaly</p> <p><input type="checkbox"/> Club foot</p> <p><input type="checkbox"/> Other: <input type="text"/></p> <p>Gastrointestinal</p> <p><input type="checkbox"/> Esophageal atresia</p> <p><input type="checkbox"/> Tracheoesophageal fistula</p> <p><input type="checkbox"/> Gastroschisis</p> <p><input type="checkbox"/> Omphalocele</p> <p><input type="checkbox"/> Pyloric stenosis</p> <p><input type="checkbox"/> Other: <input type="text"/></p> <p>Genitourinary</p> <p><input type="checkbox"/> Kidney malformation (specify below):</p> <p style="margin-left: 20px;"><input type="text"/></p> <p><input type="checkbox"/> Hydronephrosis</p> <p><input type="checkbox"/> Ambiguous genitalia</p> <p><input type="checkbox"/> Hypospadias</p> <p><input type="checkbox"/> Cryptorchidism</p> <p><input type="checkbox"/> Other: <input type="text"/></p>
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PRENATAL AND PERINATAL HISTORY

Oligohydramnios
 Polyhydramnios
 IUGR
 Premature birth

Fetal structural abnormality
 Fetal soft markers in obstetric ultrasound (specify):

Other:

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