DELIVER TO:  
CHEO Molecular Genetics Diagnostic Laboratory  
Room W3403  
401 chemin Smyth Road  
Ottawa, ON Canada K1H 8L1  
Phone: (613) 738-3230   Fax: (613) 738-4814

PATIENT NAME (LAST) (FIRST)  
ADDRESS  
CITY  PROV.  POSTAL CODE  
DATE OF BIRTH  DD/MM/YYYY  SEX:  F  M

FACILITY PATIENT ID NUMBER  
PROVINCIAL HEALTH NUMBER  
PEDIGREE NUMBER  

FOR LAB USE ONLY:  
COLLECTED BY:  
PHLEBOTOMIST COLLECTION DATE:  (DD/MM/YYYY)  
LAB NUMBER  

HEALTH CARE PROVIDER(S) REQUESTING TEST:  
NAME  
ADDRESS  
CITY  PROV.  POSTAL CODE  
CONTACT:  
PHONE NO.  FAX NO.  

AUTHORIZED SIGNATURE:  

IF AN ADDITIONAL REPORT IS BEING REQUESTED, PLEASE COMPLETE THE FOLLOWING:  
PROVIDER NAME  
ADDRESS  
CITY  PROV.  POSTAL CODE  

Test Requested  
☐ Angelman Syndrome  
☐ Charcot-Marie Tooth Type 1A  
☐ Cystic Fibrosis (ethnic background must be specified below)*  
☐ Cystinosis (ethnic background must be specified below)*  
☐ Facioscapulohumeral Muscular Dystrophy  
☐ Factor V Leiden and Factor II Prothrombin  
☐ Fetal RhD  
☐ Fetal Kell  
☐ Fetal Platelet Antigen (PLA1)  
☐ Fragile X Syndrome  
☐ Hereditary Neuropathy with Liability to Pressure Palsies  
☐ Hereditary Non-Syndromic Deafness (ethnic background must be specified below)*  
☐ HFE-related hemochromatosis  
☐ Maternal Cell Contamination Studies  
☐ Myotonic Dystrophy Type 1 (ethnic background must be specified below)*  
☐ Myotonic Dystrophy Type II  
☐ Oculopharyngeal Muscular Dystrophy  
☐ Pompe Disease  
☐ Prader-Willi Syndrome  
☐ Rett Syndrome  
☐ Spinal Muscular Atrophy  
☐ Ocular Stickler Syndrome  
☐ X-Inactivation  
☐ Zygosity Testing  
☐ Fetal Sexing  
☐ Bank DNA until further notice

* Ethnic Background (e.g. Ashkenazi Jewish, Asian, French Canadian, Northern European)

Sample Required  
☐ Blood 10 mL EDTA  
☐ Blood 3 mL EDTA (infant only)  
☐ DNA ___ ug  
☐ Other _________  
☐ Cultured Amniocytes  
☐ Amniotic Fluid 5 mL  
☐ Cultured CVS  
☐ CVS

Sample Information  
☐ Routine  
☐ Expedited  
☐ Patient/Partner Pregnant  
☐ Prenatal Diagnosis  
☐ Newborn (less than 3 months of age)

Reason for Test  
☐ Symptoms of Indicated Disease  
☐ Carrier Status  
☐ Predictive Testing  
☐ Prenatal Diagnosis (parental bloods are required)  
☐ Other:  

Additional relevant clinical and/or family history information:  

Other family member(s) tested previously:  
☐ No  
☐ Yes – name:  

relationship to patient:  

Attach copy of result (if available)  

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