SickKids®
THE HOSPITAL FOR SICK CHILDREN
Paediatric Laboratory Medicine

CYTOGENETICS LABORATORY
555 University Avenue
Room 3416, Hill Wing
Toronto, ON, M5G 1X8, Canada

Tel: 416-813-7654 ext. 302394
Fax: 416-813-7732
clinicalfibroblastservice.requests@sickkids.ca

CLINICAL FIBROBLAST SERVICE

Referred-In Requisition

Last Name:
First Name:
Date of Birth (DD/MM/YYYY):
Legal Sex: ○ *Male* ○ *Female* ○ *Non-binary/U/X*
Sex Assigned at Birth (if different): ○ *Male* ○ *Female* ○ *Unassigned*
Gender Identity: ○ *Male* ○ *Female* ○ *Non-binary/U/X*
Parent's Name:
Address:
MRN #:

For Canada Only
Provincial Health Card #: *Version:*
Issuing Province:

Testing is provided for medical purposes only and results are not intended for forensic use. The laboratory is not a forensically accredited laboratory.

SPECIMEN COLLECTION

DATE (DD/MM/YYYY) _____ **TIME** (HH:MM)_____

SHIPPING INSTRUCTIONS

- Send all specimens to Cytogenetics Laboratory at the shipping address indicated above.
- Biopsy specimens and cells in culture should be maintained at **room temperature.**

SERVICE REQUESTED

☐ **BIOPSY** - Establish cell line and Bank cells
☐ **BIOPSY** - Establish cell line, Bank cells and Sendout
☐ **FIBROBLAST CULTURE IN FLASK** - Bank
☐ **FIBROBLAST CULTURE IN FLASK** - Bank/Sendout
☐ **RETRIEVE BANKED CELL LINE** - Sendout (complete cell lines and Recipient's details)

RETRIEVAL OF EXISTING BANKED CELL LINES FOR CLINICAL USE

☐ **Banked Fibroblast Sample**
Cell Line ID# / Order #:_____

RETRIEVAL OF EXISTING BANKED CLINICAL SAMPLE FOR RESEARCH

*RESEARCH REQUESTS **MUST** BE ACCOMPANIED BY A COPY OF THE CURRENT APPROVED REB PROTOCOL AND PATIENT CONSENT FORM.*

Cell Line ID # / Order #:_____
Requesting Clinician/Investigator _____
Billing Information **(please refer to page 3)**

REQUESTING CLINICIAN / INVESTIGATOR

Name _____
Address _____

Phone_____ Fax_____
Email _____
Signature *(REQUIRED)*_____

FOR SUBMISSION OF NEW SAMPLES

☐ **Tissue biopsy in Sterile medium**
☐ Patient
Body site of biopsy _____
Age at time of biopsy _____
Collection date_____ Time _____

☐ Fetal or deceased neonate tissue
Body site of biopsy (if applicable)_____
Gestational age at sample collection _____
☐ Neonatal death ☐ Intrauterine death ☐ Stillbirth
☐ Products of conception
Phenotypic sex ☐Male ☐Female ☐Ambiguous
Collection Date _____ Time _____

☐ **Fibroblast cell culture:**
2xT25 flasks at room temperature (complete details below)

☐ **Vial of frozen fibroblasts (complete details below)**

Date culture originally established_____
Date culture frozen_____
Passage # of culture_____
Culture medium_____
Laboratory of origin_____
Body site of biopsy_____
Special instructions for growth, handling or freezing
_____
ALL INCOMING CELL LINES WILL BE TESTED FOR MYCOPLASMA

FOR ALL SENDOUT REQUESTS (INTERNAL OR EXTERNAL)

PLEASE PROVIDE COMPLETE INFORMATION

Recipient's name_____
Complete address
Institution/Testing Laboratory _____
Street_____
City_____ Postal Code _____
State/Province_____ Country _____
Telephone number _____
FedEx account number _____
Special instructions *(if any)*_____
_____

As of April 2017, Quality Control for this biorepository has been implemented according to current standards of best practice. Cell lines obtained prior to April 2017 were handled according to standards of processing in place at that time.

FOR LABORATORY USE

Date Received_____ Size of Biopsy _____
Technologist_____ Number of flasks received _____
Cell Line ID #_____ Other _____

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Gender Identity: ◯ *Male* ◯ *Female* ◯ *Non-binary/U/X*
Parent's Name:
Address:
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PHENOTYPE DESCRIPTION (clinical symptoms)

Behavior, Cognition and Development
- ☐ Global development delay
- ☐ Fine motor delay ☐ Gross motor delay
- ☐ Intellectual Disability
  - ☐ Mild
  - ☐ Moderate
  - ☐ Severe
- ☐ Other: _____

Neurological
- ☐ Hypotonia
- ☐ Seizures
- ☐ Ataxia
- ☐ Dystonia
- ☐ Chorea
- ☐ Spasticity
- ☐ Cerebral palsy
- ☐ Neural tube defect
- ☐ Abnormality of the CNS (Specify below)
- ☐ Other: _____

Growth Parameters
Weight for age: ☐ <3rd % ☐ >97th % Stature
Stature for age: ☐ <3rd % ☐ >97th % Head
Head circumference: ☐ <3rd % ☐ >97th %
- ☐ Hemihypertrophy
- ☐ Other: _____

Cardiac
- ☐ ASD
- ☐ VSD
- ☐ AV canal defect
- ☐ Coarctation of aorta
- ☐ Tetralogy of fallot
- ☐ Other: _____

Craniofacial
- ☐ Craniosynostosis
- ☐ Cleft lip ☐ Cleft palate
- ☐ Micrognathia ☐ Retrognathia
- ☐ Facial dysmorphism (Specify below)
- ☐ Other: _____

Eye Defects
- ☐ Blindness
- ☐ Coloboma
- ☐ Epicanthus ☐ Hypertelorism
- ☐ Eyelid abnormality (Specify below)
- ☐ Other: _____

Ear Defects
- ☐ Deafness
- ☐ Preauricular ☐ Pit ☐ Skin Tag
- ☐ Low-set ears
- ☐ Outer ear abnormality (Specify below)
- ☐ Inner ear abnormality (Specify below)
- ☐ Other: _____

Cutaneous
- ☐ Hyperpigmentation
- ☐ Hypopigmentation
- ☐ Other: _____

Respiratory
- ☐ Diaphragmatic hernia
- ☐ Lung abnormality (Specify below)
- ☐ Other: _____

Musculoskeletal
- ☐ Upper limb abnormality
- ☐ Lower limb abnormality
- ☐ Camptodactyly (☐ finger / ☐ toe)
- ☐ Syndactyly (☐ fingers / ☐ toes)
- ☐ Polydactyly (☐ finger / ☐ toe)
- ☐ Preaxial ☐ Postaxial
- ☐ Oligodactyly (☐ finger / ☐ toe)
- ☐ Clinodactyly (☐ finger / ☐ toe)
- ☐ Contractures
- ☐ Scoliosis
- ☐ Vertebral Anomaly
- ☐ Club foot
- ☐ Other: _____

Gastrointestinal
- ☐ Esophageal atresia
- ☐ Tracheoesophageal fistula
- ☐ Gastroschisis
- ☐ Omphalocele
- ☐ Pyloric stenosis
- ☐ Other: _____

Genitourinary
- ☐ Kidney malformation (Specify below)
- ☐ Hydronephrosis
- ☐ Ambiguous genitalia
- ☐ Hypospadias
- ☐ Cryptorchidism
- ☐ Other: _____

PRENATAL AND PERINATAL HISTORY

☐ Oligohydramnios ☐ Polyhydramnios ☐ IUGR ☐ Premature birth
☐ Fetal structural abnormality ☐ Fetal soft markers in obstetric ultrasound (Specify below)
☐ Other: _____

FAMILY HISTORY

☐ Parents with ≥ 3 miscarriages ☐ Consanguinity
☐ List health conditions found in family (describe the relationship with proband)

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Parent's Name:
Address:
MRN #:

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Issuing Province:

CLINICAL FIBROBLAST SERVICE

Referred-In Requisition

Billing Address of Hospital, Referring Laboratory, Physician, Clinic, or Medical Group (if different from requisition)

Name: _____

Address: _____

City: _____ Prov/State: _____

Postal/Zip Code: _____ Country: _____

Contact Name: _____

Contact Telephone #: _____

Please indicate payment method

Invoices are issued upon completion of test/service provided. At your direction, we will invoice the referring hospital, referring laboratory, referring physician, or research fund, for the services we render.

☐ **Send invoice for payment**

☐ Apply **charges to Fund/Study #** _____

☐ **Apply charges to credit card (complete section below)**

Complete to have charges applied to a credit card:

If you elect to have a charge applied to a credit card:

- *Charge card information must be complete; otherwise, referring client will be invoiced.*

Method of Payment (check one): ☐ American Express ☐ MasterCard ☐ Visa

Name as it appears on credit card:

Credit card #: _____

Expiry date on credit card: _____

CVS#- found on back of card (Required):

LABORATORY USE ONLY

Client Code / Account #: _____

Specimen / Accession #: _____

Cell Culture Lab #: _____