SickKids®
THE HOSPITAL FOR SICK CHILDREN
Paediatric Laboratory Medicine

CYTOGENETICS LABORATORY
555 University Avenue
Room 3416, Hill Wing
Toronto, ON, M5G 1X8, Canada
Tel: 416-813-7200 x 1
Fax: 416-813-7732
(CLIA # 99D1014032)

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:

CONSTITUTIONAL ANALYSIS

Referred-In Requisition

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)

SPECIMEN TYPE

☐ **Blood** at room temperature, in **sodium heparin** collection tubes
Volume: **0–3 months:** 1–3mL; **3 months–12 years:** 3–6mL
12 years–adult: 6mL
☐ **Tissue** in sterile medium/saline

SHIPPING INSTRUCTIONS

- Send all specimens to Cytogenetics Laboratory, at the shipping address indicated above.

TESTS

☐ **KARYOTYPE** ***Note for External Clients:*** For paediatric testing only.

RAPID FISH (13, 18, 21, X/Y for newborn only; BMT XX/XY - all ages)

☐ Down Syndrome
☐ Trisomy 13
☐ Trisomy 18
☐ CEPX/CEPY for ambiguous genitalia
☐ BMT Monitor by XX/XY FISH

FISH

☐ Wolf-Hirschhorn (4p16)
☐ Williams (7q11.23)
☐ Prader-Willi (15q11.2)
☐ Angelman (15q11.2)
☐ Smith-Magenis (17p11.2)
☐ Microdeletion 22q11.2
☐ X/SRY (Yp11.3)
☐ SHOX (Xp22.3/Yp11.3)
☐ Other: _____

MICROARRAY FOLLOW UP

☐ FISH
☐ Karyotype
☐ Proband
☐ Family Member
Relationship to Proband: _____
Copy Number Change for follow up _____
Microarray Report/Order #, if available _____

CHROMOSOME BREAKAGE SYNDROMES

☐ Fanconi Anemia *(Monday or Tuesday preferred)*
☐ Bloom *(Monday or Tuesday preferred)*
☐ Ataxia Telangiectasia
☐ Spontaneous Breakage

INDICATIONS

☐ Down Syndrome
☐ Trisomy 13 Syndrome
☐ Trisomy 18 Syndrome
☐ Turner Syndrome
☐ Klinefelter Syndrome

☐ Stillbirth (gestational age > 20 wks)
☐ Neonatal death
☐ Congenital malformation(s) _____
☐ Cardiac malformation(s) _____
☐ Ambiguous genitalia _____

☐ Dysmorphic features
☐ Developmental delay
☐ Intellectual Disability
☐ Behavioural problems
☐ Delayed puberty
☐ Multiple miscarriages
☐ Failure to thrive
☐ Hypotonia
☐ Short stature
☐ Query Mosaicism
☐ Amenorrhea
☐ Infertility

☐ Family History of (provide report , if available) _____
☐ Other: _____

☐ Ataxia
☐ Telangiectasia
☐ Elevated AFP level
☐ Aplastic anemia
☐ Bone marrow failure
☐ Malignancy: Describe _____
☐ Current/Previous Chemotherapeutic and/or Radiation Treatment:
Describe _____

Comments

Referring Physician

Name (print) _____

Phone _____ Fax _____

Copy of Report

Name (print) _____

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CONSTITUTIONAL ANALYSIS

Billing Form

The hospital, referring laboratory, or a patient/guardian will be billed for the services rendered.

- Invoices are sent upon completion of each test/service.
- Contact SickKids' Cytogenetics Laboratory at 416-813-7200 x1 with billing inquiries.

Completion of Billing Form NOT required for patients with an Ontario Health Card Number.

How to complete the Billing Form:

- **Referring Physician completes the appropriate section below to specify billing method.**
- **Send requisition and completed "Billing Form" with specimen.**

Option 1: Complete to have the Healthcare Provider billed:

Your Referring Laboratory's Reference #: _____

Billing address of hospital, referring laboratory:

Name:_____ Address: _____

_____

City:_____ Prov/State: _____

Postal/Zip Code:_____ Country: _____

Contact Name: _____

Contact Telephone #: _____

Option 2: Interm Federal Health Program (IFHP)

Submit a copy of the Interim Federal Health Certificate (Refugee Protection Claimant Document) with the photo and UCI# visible for coverage to be confirmed.

UCI# _____

ICD code *(lab use only)*:_____

Section 2: Complete to have Patient/Guardian billed directly:

If you elect to have patient/guardian billed:

- *Patient/Guardian billing information below must be complete; otherwise, the healthcare provider will be billed.*
- *Please advise the patient/guardian to expect a bill from our laboratory.*
- *Provide us with patient's valid credit card information.*
- *Unfortunately, we cannot accept personal checks.*
- ***In this case, the patient/guardian is solely responsible for the charges.***

Send bill to (check one): ☐ Patient ☐ Guardian/Parent

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):

Mailing Address of Patient/Guardian (if different from requisition):

Name: _____

Address: _____

_____ Apt. #: _____

City:_____ Prov/State: _____

Postal/Zip Code:_____ Country: _____

Additional Contact Information

Patient's phone # with area code:

_____

- or -

Guardian's phone # with area code:

_____