SickKids
THE HOSPITAL FOR SICK CHILDREN
Paediatric Laboratory Medicine

CYTOGENETICS LABORATORY
555 University Avenue
Room 3415, Black Wing
Toronto, ON, M5G 1X8, Canada

Tel: 416-813-7200 x 1
Fax: 416-813-7732
(CLIA # 99D1014032)

Patient Name:
Date of Birth (DD/MM/YYYY):
Gender: ☐ *Male* ☐ *Female*
Parent's Name:
Address:

MRN#:

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

CONSTITUTIONAL ANALYSIS

Referred-In Requisition

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:*** Valid indication(s) required for cytogenetic analysis.

RAPID FISH

☐ Down Syndrome
☐ Trisomy 13
☐ Trisomy 18
☐ X/SRY (Yp11.3)
☐ BMT Monitor by XX/XY FISH

FISH

☐ Wolf-Hirschhorn (4p16)
☐ Williams (7q11.23)
☐ Prader-Willi (15q11.2)
☐ Angelman (15q11.2)
☐ Microarray Follow Up FISH
  ☐ Proband
  ☐ Family Member
  Relationship to Proband: _____
☐ Smith-Magenis (17p11.2)
☐ Microdeletion 22q11.2
☐ X/SRY (Yp11.3)
☐ SHOX (Xp22.3/Yp11.3)
☐ Other: _____

Copy Number Change for follow up _____

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 (self or partner)
☐ Failure to thrive
☐ Hypotonia
☐ Short stature
☐ query Mosaicism
☐ Amenorrhea
☐ Infertility
☐ Family history of _____
☐ 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) _____
Address _____
_____
Phone _____ Fax _____
Signature (required) _____

Copy of Report

Name (print) _____
Address _____
_____
_____

FOR LABORATORY USE

Lab #: _____ **Date Received** _____
Lab #: _____ **Date Cultured** _____
Technologist: _____ **Date Harvested** _____

GENETICS

If part of family study: _____
Name of Proband: _____
Relation to Proband: _____

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

CONSTITUTIONAL ANALYSIS

Billing Form

At your direction, we will bill the hospital, referring laboratory, referring physician, or a patient/guardian, for the services we render

- Invoices are sent upon completion of each test/service.
- Invoices are itemized and include the date of service, patient name, test name and charge.
- Contact SickKids' Cytogenetics Laboratory at 416-813-7200 x1 with billing inquiries.

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.**

Section 1: Complete to have the Healthcare Provider billed:

Your Referring Laboratory's Reference #: _____

Billing address of hospital, referring laboratory, clinic, referring physician, or medical group: (if different from requisition):

Name: _____

Address: _____

City: _____ Prov/State: _____

Postal/Zip Code: _____ Country: _____

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

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

Name as it appears on credit card: _____

Credit card # : _____

Expiry date on credit card: _____

Signature of credit card holder (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:

_____