SickKids®
THE HOSPITAL FOR SICK CHILDREN
Paediatric Laboratory Medicine

555 University Avenue
Room 3416, Roy C. Hill Wing
Toronto, ON, M5G 1X8, Canada

Tel: 416-813-7200 x1
Fax: 416-813-7732

(CLIA # 99D1014032)

Genome Diagnostics

www.sickkids.ca/genome-diagnostics

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

Telephone #:
For Canada Only (Billing section must be completed for all non-OHIP)
Provincial Health Card #: *Version:*
Issuing Province:

Referring Physician:

Name: _____

Facility/Ward/Clinic *(required)*: _____

Address: _____

_____

Phone _____ Fax _____

Email address: _____

Signature *(required)* _____

Copy Report To *(if selected, all below information is required)*:

Name: _____

Address: _____

_____

Phone _____ Fax _____

Sample Information:

Date obtained (DD/MM/YYYY): _____ -_____-_____

Referring laboratory reference #: _____

- ☐ Blood in EDTA (purple top tube): min. 4 mL (0.5-3 mL for newborns)
- ☐ DNA: min.10 ug in low TE buffer (Source: _____)
- ☐ Direct CVS: min. 10 mg direct villi
- ☐ Cultured villi: 1-2 confluent T25 flasks
- ☐ Cultured amniocytes: 1-2 confluent T25 flasks
- ☐ Tissue (Source: _____)
- ☐ Other (Specify: _____)

Closed consent:

☐ (If checked, all remaining DNA will be discarded upon notification by the ordering physician that all DNA testing has been completed)

Laboratory Use:

Date (DD/MM/YYYY) | **Time Received**:

_____ - _____ - _____ | _____ h

Lab #: _____

Specimen type, amt & # of tubes: _____

Comments:

Pedigree No. / Patient No. _____ / _____

Test request *(write below and/ or check box(es) on pages 2 and 3)*:

_____

Reason for Testing:

- ☐ Diagnosis
- ☐ Carrier testing
- ☐ Familial mutation/variant analysis
- ☐ Prenatal testing
- ☐ Bank DNA only
- ☐ Other (Specify): _____

If expedited testing is requested, indicate reason

- ☐ Pregnancy (Gestational age (weeks): _____)
- ☐ Other (Specify: _____)

Familial Mutation/Variant Analysis:

For prenatal testing and cases where a familial mutation or variant is known, complete below and attach a copy of the proband's report:

Gene & NM#: _____

Mutation/variant(s): _____

SickKids Laboratory/Order number: _____

SickKids Pedigree/Family number: _____

Name of proband: _____

Relationship to proband/fetus: _____

Name(s) & DOB of other submitted family members _____

_____

Ordering Checklist:

- ☐ Specimen tube labeled with at least two identifiers
- ☐ Completed test requisition form *(pages 1-5)*
  Clinical information must be provided on pages 4 -5 for all Next-Generation Sequencing tests. Testing will not proceed until these are provided.
- ☐ Completed billing form *(page 6, if applicable)*

Clinical Diagnostics and Family History:

Draw or attach a pedigree and provide any relevant information below, including clinical and family history details, as this is important for accurate interpretation of results

Ethnicity: _____

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LIST OF TESTS AVAILABLE BY DISEASE

For prenatal testing and cases where a familial mutation/variant is known, please include information on page 1.

22q11 Deletion Syndrome
☐ 22q11 deletion/duplication analysis

Angelman Syndrome
☐ Methylation and deletion/duplication analysis
☐ UPD15 analysis *(submit parental samples)*

Arrhythmogenic Right Ventricular Cardiomyopathy
☐ Sequence analysis panel:
DSC2, DSG2, DSP, PKP2, TMEM43

Ashkenazi Jewish Carrier Screening
Use: **Carrier Screening: Tay-Sachs Enzyme Testing & Ashkenazi Jewish Molecular Panel Requisition**

Atypical Hemolytic Uremic Syndrome / Membranoproliferative Glomerulonephritis
☐ Sequence analysis panel

Autoinflammatory Disease *
Clinical information must be provided on pages 4 and 5
☐ Recurrent Fever Syndrome (RFS) NGS panel
☐ Hemophagocytic Lymphohistiocytosis (HLH) NGS panel
☐ Deletion/duplication analysis

Becker Muscular Dystrophy
☐ *DMD* Sequence analysis
☐ *DMD* deletion/duplication analysis

Beckwith-Wiedemann Syndrome
☐ IC1 and IC2 methylation and 11p15 deletion/duplication analysis
☐ UPD11 analysis
☐ *CDKN1C* Sequence analysis

Bone Marrow Transplantation
☐ Post-transplant monitoring

Branchio-Oto-Renal Syndrome
☐ *EYA1* Sequence analysis
☐ *EYA1* deletion/duplication analysis

Caffey Disease
☐ *COL1A1* recurrent mutation analysis

Cancer Related Tests

Li-Fraumeni Syndrome
☐ *TP53* Sequence analysis
☐ *TP53* deletion/duplication analysis

Rhabdoid Tumour Predisposition Syndrome
☐ *SMARCB1* Sequence analysis
☐ *SMARCB1* deletion/duplication analysis

Charge Syndrome
☐ *CHD7* sequence analysis
☐ *CHD7* deletion/duplication analysis

Cherubism
☐ *SH3BP2* recurrent mutation analysis
☐ *SH3BP2* sequence analysis

Congenital Muscular Dystrophies
☐ Sequence analysis panel:
FKTN (FCMD), FKRP, POMGnT1, POMT1, POMT2

Connective Tissue Disease *
Clinical information must be provided on pages 4 and 5
If more than one panel is requested, rationale must be provided on page 5.
☐ Ehlers Danlos Syndrome NGS panel
☐ Osteogenesis Imperfecta NGS panel
☐ Osteopetrosis and Disorders of Increased Bone Density NGS panel
☐ Bone Involvement NGS panel
☐ Deletion/duplication analysis

Craniosynostosis
☐ Apert Syndrome (*FGFR2* recurrent mutations analysis)
☐ Crouzon Syndrome (*FGFR2, FGFR3* recurrent mutation analysis)
☐ Pfeiffer Syndrome (*FGFR1, FGFR2, FGFR3* recurrent mutation analysis)
☐ Saethre-Chotzen Syndrome (*TWIST1* sequence analysis and *FGFR3* recurrent mutation analysis)
☐ Non-Syndromic Craniosynostosis (*FGFR3* recurrent mutation analysis)
☐ *TWIST1* deletion/duplication analysis

Cystic Fibrosis
For prenatal echogenic bowel, ensure parental samples are linked to each other on both requisitions with at least two identi iers. Ensure "echogenic bowel" is indicated on the Family History section on Page 1.
☐ *CFTR* recurrent mutation analysis
☐ *CFTR* Sequence analysis
☐ *CFTR* deletion/duplication analysis

Dopamine Beta-Hydroxylase Deficiency
☐ *DBH* Sequence analysis

Duchenne Muscular Dystrophy
☐ *DMD* Sequence analysis
☐ *DMD* deletion/duplication analysis
☐ *DMD* mRNA analysis *(contact the laboratory before ordering)*

Fabry Disease
☐ *GLA* Sequence analysis
☐ *GLA* deletion/duplication analysis
☐ *GLA* mRNA analysis *(contact the laboratory before ordering)*

Focal Segmental Glomerulosclerosis
☐ Sequence analysis panel

Fragile X Syndrome
☐ *FMR1* trinucleotide repeat analysis

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For prenatal testing and cases where a familial mutation/variant is known, please include information on page 1.

Fragile X E Syndrome **

☐ *AFF2* trinucleotide repeat analysis
(See testing requirements)

Gaucher Disease

☐ *GBA* recurrent mutation analysis

Hearing Loss: Non-Syndromic, Autosomal Recessive

☐ *GJB2* Sequence analysis
☐ *GJB6* deletion/duplication analysis

Hearing Loss: Aminoglycoside-induced, Mitochondrial

☐ *MTRNR1, MTTS1* recurrent mutation analysis

Hearing Loss: Pendred Syndrome

☐ *SLC26A4* Sequence analysis
☐ *SLC26A4* deletion/duplication analysis

Hereditary Hearing Loss *

Clinical information must be provided on pages 4 and 5

When the Common and Non-syndromic Hearing Loss Panel is requested, STRC dosage is tested.

☐ Common and Non-syndromic Hearing Loss NGS panel
☐ Usher Syndrome NGS panel
☐ Stickler Syndrome NGS panel
☐ Alport Syndrome, Norrie Syndrome, Treacher Collins Syndrome, Waardenburg Syndrome NGS panel
☐ Deletion/duplication analysis

Hereditary Hemorrhagic Telangiectasia

☐ *ACVRL1* Sequence analysis
☐ *ENG* Sequence analysis
☐ *ACVRL1* and *ENG* deletion/duplication analysis
☐ *SMAD4* Sequence analysis

Hereditary Spastic Paraplegia *

Clinical information must be provided on pages 4 and 5

☐ Autosomal Dominant HSP NGS panel
☐ Autosomal Recessive HSP NGS panel
☐ X-Linked HSP NGS panel
☐ Deletion/duplication analysis

Hunter Disease

☐ *IDS* Sequence analysis
☐ *IDS* deletion/duplication analysis
☐ *IDS* mRNA analysis *(contact the laboratory before ordering)*

Identity Testing

☐ Zygosity studies

☐ Maternal Cell Contamination Studies

(maternal sample required)

Neurofibromatosis type 1/Legius syndrome *

Clinical information must be provided on pages 4 and 5

☐ *NF1* sequence analysis
☐ *NF1* deletion/duplication analysis
☐ *SPRED1* sequence analysis
☐ *SPRED1* deletion/duplication analysis

Neuronal Ceroid Lipofuscinoses (Batten Disease)

☐ *PPT1 (CLN1), TPP1 (CLN2)* and *CLN3* recurrent mutation analysis
☐ Sequence analysis panel:
PPT1(CLN1), TPP1 (CLN2), CLN3, CLN5, CLN6, CLN7, CLN8, CLN10

Noonan Syndrome and RASopathies *

Clinical information must be provided on pages 4 and 5

☐ Noonan Syndrome and RASopathies panel
☐ Deletion/duplication analysis for *SPRED1* only

Prader-Willi Syndrome

☐ Methylation and deletion/duplication analysis
☐ UPD15 analysis *(parental samples required)*

Russell-Silver Syndrome

☐ *IC1* methylation and 11p15 deletion/duplication analysis
☐ *UPD7* analysis *(parental samples required)*

Shwachman-Diamond Syndrome

☐ *SBDS* Sequence analysis

Simpson-Golabi-Behmel Syndrome

☐ *GPC3* sequence analysis and *GPC3* and *GPC4* deletion/duplication analysis

Skeletal Dysplasia

☐ Achondroplasia (*FGFR3* recurrent mutation analysis)
☐ Hypochondroplasia (*FGFR3* recurrent mutation analysis)
☐ Thanatophoric Dysplasia (*FGFR3* recurrent mutation analysis)

Spinal and Bulbar Muscular Atrophy

☐ *AR* trinucleotide repeat analysis

Spinal Muscular Atrophy

☐ *SMN1* and *SMN2* deletion/duplication analysis

Trismus Pseudocamptodactyly Syndrome

☐ *MYH8* Sequence analysis

☐ X-Inactivation Analysis

☐ Other: _____

* **Next-Generation Sequencing (NGS) testing will only be initiated if the clinical information sections, located on pages 4 and 5 of the requisition form, are completed. For more information on our Next-Generation Sequencing (NGS) panels, including the list of genes tested, please visit our website: www.sickkids.ca/genome-diagnostics**

** **For information on the testing requirement for Fragile X E, please visit the Specimen Requirements section for Fragile X E Syndrome on our website: www.sickkids.ca/genome-diagnostics/FragileXE**

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Clinical Information *(Required)*

DISEASE SPECIFIC FEATURES

Autoinflammatory Disorders (RFS/HLH)

- ☐ Abnormal inflammatory response
- ☐ Fevers
- ☐ Arthritis
- ☐ Pulmonary complications
- ☐ Gastrointestinal irritation
- ☐ Hepatosplenomegaly
- ☐ Lymphadenopathy
- ☐ Hemophagocytosis
- ☐ Oral ulcers
- ☐ Rash, specify: _____
- ☐ Ocular inflammation specify: _____
- ☐ Edema (periorbital, optic disk)
- ☐ Vision loss
- ☐ Other: _____

Hearing Loss

- ☐ Age of onset: _____
- ☐ Sensorineural hearing loss
- ☐ Conductive hearing loss
- ☐ Mixed hearing loss
- ☐ Bilateral ☐ Unilateral
- ☐ Syndromic ☐ Non-syndromic
- ☐ Ear anomalies ☐ Ear tags
- ☐ Eye anomalies ☐ Renal anomalies
- ☐ White forelock ☐ Cardiac anomalies
- ☐ Hirschsprung disease
- ☐ Other: _____

Hereditary Spastic Paraplegia (HSP)

- ☐ Abnormal corpus callosum
- ☐ Cognitive impairment
- ☐ Ataxia ☐ Spasticity
- ☐ Hyperreflexia ☐ Seizures
- ☐ Hypertonia ☐ Hypotonia
- ☐ Dystonia ☐ Dysarthria
- ☐ Extensor plantar reflex
- ☐ Other: _____

The following investigations are required before molecular testing of HSP is undertaken:

- ☐ MRI – Brain and spinal cord
- ☐ Biochemical testing - Vitamin B12, vitamin E, very long chain fatty acids, lysosomal work-up, plasma amino acids and serum lipoprotein analysis (as appropriate)

Neurofibromatosis type 1 (NF1) / Legius Syndrome

- ☐ **The patient meets the NIH criteria for a clinical diagnosis of NF1 (≥2 of the clinical features below).**
- ☐ Café-au-lait macules
  - ☐ ≥6 CALS ☐ (#: _____)
- ☐ Neurofibromas, ≥ 2 or ≥ 1 Plexiform
- ☐ Freckling, axillary or inguinal
- ☐ Optic glioma
- ☐ ≥2 Lisch nodules (iris hamartomas)
- ☐ Osseous lesion (type: _____)
- ☐ First degree relative diagnosed with NF1 by above criteria
- ☐ Other: _____
- ☐ **The patient does not meet the NIH diagnostic criteria for NF1. Rationale for testing must be provided on page 5.**

Connective Tissue Disorders (CTD)

Ehlers Danlos Syndrome (EDS)

Indicate the suspected clinical diagnosis in the patient:

- ☐ Classic ☐ Vascular
- ☐ Kyphoscoliotic ☐ Other: _____

Note: Genetic testing is not offered for joint hypermobility alone. If testing is requested for joint hypermobility, provide rationale on page 5.

Check applicable CTD features below.

Osteopetrosis and Disorders of Increased Bone Density

Check applicable CTD features below.

Osteogenesis Imperfecta (OI)

If the patient does not present with one of the test indications below, rationale for testing must be provided on page 5.

- ☐ Fetal findings on anatomy ultrasound consistent with OI.
- ☐ Fractures with minimal or no trauma in the absence of other known disorders of bone metabolism.
- ☐ Vertebral fractures
- ☐ Dentinogenesis imperfecta
- ☐ Low ALP for age/gender (ALPL analysis only will be performed)

Check applicable CTD features below.

Bone Involvement

Check applicable CTD features below.

CTD Related Clinical Features:

- ☐ Joint hypermobility: Beighton score: _____
- ☐ Arterial aneurysms, dissection or rupture
- ☐ Intestinal rupture
- ☐ Molluscoid pseudotumors
- ☐ Subcutaneous spheroids
- ☐ Loose/stretchable skin
- ☐ Smooth/velvety skin
- ☐ Widened atrophic scars
- ☐ Recurrent spontaneous tendon rupture
- ☐ Easy bruising
- ☐ Myopia
- ☐ Lens dislocation
- ☐ Blue/gray sclerae
- ☐ Thumb or wrist sign
- ☐ Club foot
- ☐ Scoliosis
- ☐ Marfanoid habitus
- ☐ Short stature
- ☐ Shortened long bones
- ☐ Recurrent pneumothoraces
- ☐ Joint subluxations/dislocations
- ☐ Fractures
- ☐ Bone deformity
- ☐ Wormian bones
- ☐ Increased bone mineral density
- ☐ Diaphyseal sclerosis
- ☐ Hearing loss
- ☐ Osteosclerosis
- ☐ Other: _____

Noonan Syndrome and RASopathies

- ☐ Increased nuchal translucency
- ☐ Developmental delay
- ☐ Characteristic facies
- ☐ Broad or webbed neck
- ☐ Heart defect (specify: _____)
- ☐ Hypertrophic cardiomyopathy
- ☐ Short stature (%ile: _____)
- ☐ Pectus deformity
- ☐ Lymphatic dysplasias
- ☐ Characteristic hematological abnormality (specify: _____)
- ☐ Other RASopathy features: (specify: _____)
- ☐ **For postnatal patients: The patient must present with ≥2 of the above features for molecular testing to be undertaken.**

FAMILY HISTORY

Please draw or attach a pedigree and provide any relevant information below, including clinical and family history details, as this is important for accurate interpretation of results.

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Clinical Information *(Required)*

ADDITIONAL RELEVANT CLINICAL INFORMATION

Previous Genetic Testing

☐ No

☐ Yes – Test Results _____

GENERAL CLINICAL FEATURES

Perinatal history
☐ Premature birth
☐ IUGR
☐ Oligohydramnios ☐ Polyhydramnios
☐ Other: _____

Growth
☐ Failure to thrive
☐ Growth retardation/short stature
☐ Overgrowth
☐ Macrocephaly ☐ Microcephaly
☐ Other: _____

Physical/cognitive development
☐ Delayed fine motor development
☐ Delayed gross motor development
☐ Delayed speech and language
☐ Autistic behavior
☐ Intellectual disability
☐ Developmental regression
☐ Other: _____

Behavioral
☐ Autistic features
☐ Obsessive-compulsive disorder
☐ Other psychiatric symptoms
☐ Other: _____

Cancer/Malignancy
☐ Age of onset: _____
☐ Tumor type: _____
☐ Location(s): _____

Craniofacial/Ophthalmalogic
☐ Abnormal face shape
☐ Blindness ☐ Cataracts
☐ Coloboma ☐ Optic atrophy
☐ Opthalmoplegia ☐ Ptosis
☐ Retinitis pigmentosa
☐ Oral cleft
☐ Other: _____

Brain malformations/ abnormal imaging
☐ Abnormality of the basal ganglia
☐ Agenesis of the corpus callosum
☐ Brain atrophy
☐ Cortical dysplasia
☐ Hemimegalencephaly
☐ Heterotopia
☐ Holoprosencephaly
☐ Hydrocephalus
☐ Lissencephaly
☐ Periventricular leukomalacia
☐ Other: _____

Cardiac/congenital heart malformations
☐ ASD ☐ VSD
☐ Coarctation of aorta
☐ Hypoplastic left heart
☐ Tetralogy of Fallot
☐ Cardiomyopathy
☐ Arrhythmia/conduction defect
☐ Other: _____

Gastrointestinal
☐ Gastroschisis/omphalocele
☐ Gastrointestinal reflux
☐ Pyloric stenosis
☐ Tracheoesophageal fistula
☐ Hepatic failure
☐ Chronic intestinal pseudo-obstruction
☐ Hirschsprung disease
☐ Recurrent vomiting
☐ Chronic diarrhea
☐ Constipation
☐ Other: _____

Genitourinary abnormalities
☐ Ambiguous genitalia
☐ Cryptorchidism
☐ Hypospadias
☐ Hydronephrosis
☐ Kidney malformation
☐ Renal agenesis
☐ Proximal renal tubulopathy
☐ Other: _____

Endocrine
☐ Diabetes mellitus Type 1
☐ Diabetes mellitus Type 2
☐ Hypothyroidism
☐ Hypoparathyroidism
☐ Pheochromocytoma/paraganglioma
☐ Other: _____

Neurological/Muscular
☐ Ataxia ☐ Hypotonia
☐ Chorea ☐ Hypertonia
☐ Dystonia ☐ Spasticity
☐ Exercise intolerance/ easy fatigue
☐ Headache/migraine
☐ Muscle weakness
☐ Seizures (type: _____)
☐ Stroke/stroke-like episodes
☐ Other: _____

Skeletal/Limb abnormalities
☐ Contractures ☐ Club foot
☐ Polydactyly ☐ Syndactyly
☐ Vertebral anomaly ☐ Scoliosis
☐ Other: _____

Skin/Hair
☐ Abnormality of the hair pattern, quantity
☐ Abnormal nail growth
☐ Abnormal pigmentation
☐ Café-au-lait macules
☐ Neoplasms of the skin
☐ Neurofibromas
☐ Blistering
☐ Ichthyosis
☐ Other: _____

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

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' Genome Diagnostics 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:

Name: _____

Address: _____

City: _____ Prov/State: _____

Postal/Zip Code: _____ Country: _____

Contact Name: _____ Contact Telephone #: _____

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.***

Relation to patient (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:

_____