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

*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*
*MRN #:*
*Address:*
*Parent's Name:*
***For Canada Only***
***Health Card #:*** ***Version:***
*Issuing Province:*

# CLINICAL FIBROBLAST SERVICE

**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) _____

## 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

- ☐ Establish cell line and Bank cells
- ☐ Establish cell line, Bank cells and Send out
- ☐ Culture cells for immediate testing (no banking of cell line)
- ☐ Expand cell line and Bank cells
- ☐ Expand cell line, Bank cells and Send out

## For All Send out 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)* _____
_____

## Requesting Clinician / Investigator

Name _____
Address _____
Phone _____ Fax _____
Email _____
Signature _____

## Retrieval of Existing Banked Cell Lines for Clinical Use

☐ **Banked Fibroblast Sample**
Cell Culture Lab #: _____

## Retrieval of Existing Banked Clinical Sample for Research

*REQUESTS FOR SICKKIDS RESEARCH STUDIES REQUIRE AN UPFRONT SERVICE AGREEMENT. PLEASE CONTACT.* dplm/researchrequests@sickkids.ca.

Cell Culture Lab #: _____
Requesting Clinician/Investigator: _____
REB #: _____
DPLM Research Request reference # (for SickKids studies only): _____

*As of April 2017, Quality Control for this biorepository has been implemented according to current best practices. Cell lines obtained before April 2017 were handled according to the processing standards at that time.*

## For Submission of New Samples

☐ **Tissue biopsy in sterile medium/saline**
- ☐ 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 ☐ Inter uterine death ☐ Stillbirth
- ☐ Products of conception
- Phenotypic sex ☐ Male ☐ Female ☐ Ambiguous
- Collection date _____ Time _____

☐ **Fibroblast cell culture: 2xT25 flasks at room temperature**
☐ **Vial of frozen fibroblasts**
*ALL INCOMING CELL LINES WILL BE TESTED FOR MYCOPLASMA AT COST TO THE USER*
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 _____

## Diagnosis

- ☐ Not yet known
- ☐ Brain abnormality Specify _____
- ☐ Cephalic disorder Specify _____
- ☐ Connective tissue disorder Specify _____
- ☐ Mitochondrial disorder Specify _____
- ☐ Metabolic disorder Specify _____
- ☐ Neural tube defect Specify _____
- ☐ Skeletal dyplasia Specify _____
- ☐ Arthrogryposis
- ☐ Cystic hygroma ☐ Hydrops
- ☐ Epilepsy ☐ Intrauterine growth disorder
- ☐ Hemihyperplasia ☐ Severe Combined Immune Defi
- ☐ Hydrocephalus ☐ Wilms tumour
- ☐ Other Specify _____

Family history _____

## For Laboratory Use

Date Received _____ Size of Biopsy _____
Technologist _____ Number of flasks received _____
Cell Line ID # _____ Other _____
Genetics # _____ _____

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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 for age: ☐ <3rd % ☐ >97th %
- 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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**Referred-In Requisition**

## 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 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: _____

CVC# (on back of card): _____

## Laboratory Use Only

**Client code / account #:** _____

**Specimen / accession #:** _____

**Cell culture lab #:** _____