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

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

MRN#:

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

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 Sendout
☐ Culture cells for immediate testing (no banking of cell line)
☐ Expand cell line and Bank cells
☐ Expand cell line, Bank cells and Sendout

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)* ____________

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

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

Cell Culture Lab # ____________
Requesting Clinician/Investigator ____________
Cost Centre/Billing Information **(please refer to page 3)**

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 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
☐ Epilepsy
☐ Hemihyperplasia
☐ Hydrocephalus
☐ Other
☐ Hydrops
☐ Intrauterine growth disorder
☐ Severe Combined Immune Deficiency
☐ Wilms tumour
Specify ____________
Family history ____________
Ethnicity ____________

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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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: ____________________

CVC# (on back of card): ____________________

LABORATORY USE ONLY

Client Code / Account #: ____________________

Specimen / Accession #: ____________________

Cell Culture Lab #: ____________________