ALBERTA PRECISION LABORATORIES
Leaders in Laboratory Medicine

Molecular Genetics Laboratory Cardiac, Connective Tissue and Vascular NGS Requisition

For detailed testing information, refer to
APL Test Directory: http://ahsweb.ca/lab/apl-td-lab-test-directory
APL Genetics & Genomics Website:
http://ahsweb.ca/lab/if-lab-genetics-and-genomics

Scanning Label or Accession # *(lab only)*

Patient

PHN Expiry: _____	Date of Birth *(dd-Mon-yyyy)*		
Legal Last Name	Legal First Name	Middle Name	
Alternate Identifier	Preferred Name	☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to disclose	Phone
Address	City/Town	Prov	Postal Code

Provider(s)

Authorizing Provider Name *(last, first, middle)*		Copy to Name *(last, first, middle)*	Copy to Name *(last, first, middle)*
Address	Phone	Address	Address
CC Provider ID	CC Submitter ID	Phone	Phone
Clinic Name		Clinic Name	Clinic Name

Collection

Date *(dd-Mon-yyyy)*	Time *(24 hr)*	Location	Collector ID

Genetic Counsellor/Clinic Contact Name *(last, first)*	Phone

Specimen

☐ Whole Blood in EDTA tube ☐ Extracted DNA ☐ Fluid, amniotic*
☐ Tissue, chorionic villi* ☐ Cord blood* ☐ Other *(specify)* _____

**If specimen type is prenatal or cord blood, maternal specimen must be collected for maternal cell contamination studies*

Health Care Provider Important Information

- All sections of the requisition must be completed.
- By providing this requisition to the patient/family, the health care provider confirms that they have reviewed the pre-test counselling information *(available on the Genetics & Genomics website)* with the patient/family, and the patient/family consents to testing.
- Direct patient to take requisition to a local blood collection location to have blood specimen drawn.

Billing Information: Must be completed if the patient does not have a valid Alberta Personal Heath Number.

Genetic testing is not covered by inter-provincial billing agreements. Alberta Precision Laboratories (APL) will bill a provincial medical services plan provided there is a letter of pre-approval received with the requisition or Institutional Billing information provided below. By completing the Institutional Billing section, the health care provider confirms they have obtained any necessary pre-approval. For patient pay, contact the testing laboratory.

Institutional Billing Information *(if pre-approval letter not attached)*

Address	
Contact Name *(last, first)*	
Phone	Fax

MGL Use Only

Patient Number	Family Number	Received	Quantity

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Last Name *(Legal)*	First Name *(Legal)*
PHN	

Section I - Reason for Testing *(select one only)*

☐ Confirmation of Diagnosis *(Patient has signs or symptoms of the disease/disorder)*
☐ Presymptomatic or Predictive Testing *(Patient does not presently have symptoms; positive family history)*
☐ Carrier Testing *(No symptoms; at risk of being a carrier of a recessive disorder)*
☐ Required for Family Study
☐ Prenatal Testing
☐ Other _____

Section II - Family History

Family History of Indicated Disease ☐ Unknown ☐ No known ☐ Possible ☐ Documented

Documented Family History
☐ Clinical diagnosis ONLY
☐ Molecular diagnosis *(provide a copy of the familial variant report if the testing was performed at another laboratory)*

Have family members of your patient previously been tested by the Molecular Genetics Lab (MGL)?
☐ Yes ☐ No *(if yes, provide details below)* ▼

Family Member Name(s) _____

MGL Reference Number(s) _____

Relationship to Index Patient _____

Is RUSH testing needed? ☐ Yes ☐ No *(if yes checked, provide details below)* ▼
☐ Results will alter the **immediate** management and/or treatment of this patient (*specify)* _____
☐ Results will impact an ongoing pregnancy *(provide EDD, and procedure date if applicable)* _____

Section III - Patient Clinical Information

Sex at Birth ☐ Female ☐ Male ☐ Unknown

Has this patient received a blood product in the preceding three months?
☐ Yes indicate blood product _____ ☐ No

Has the patient had a bone marrow transplant?
☐ Yes ***(Blood is an incompatible specimen type)*** ☐ No

Provide any relevant information regarding your patient's clinical presentation:

Section IV - Pedigree *(Provide any relevant family history details, with family member names, ages, and diagnoses included as applicable. If more space is required, attach a separate sheet.)*

Patient Ethnicity/Ancestry _____

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Section V - Specific Variant Testing *(Complete this section only if you are requesting testing for a variant previously identified in the family. Specific variant testing is available for all genes available on the panels listed below.)*

☐ Cardiac Gene Panel, Specific Variant ☐ Connective Tissue Disorder Panel, Specific Variant ☐ Inherited Vascular Disorder Panel, Specific Variant	Gene Mutation/Variant

Relationship to Index Patient _____

What is the phenotype/presentation in the index patient? _____

Other family members previously tested in MGL ☐ No ☐ Yes ▼

Family Member Name(s) _____

MGL Reference Number(s) _____

Which laboratory performed the proband testing? ☐ Calgary ☐ Edmonton ☐ Other *(specify)* _____

Testing a positive control is recommended if the proband testing was performed at another lab.
A clear copy of the test report on a family member is required if the testing was performed at another laboratory.

Section VI – Cardiac, Connective Tissue, and Vascular Gene Panel Requests

Inherited Arrhythmias

- ☐ Brugada Syndrome
- ☐ Catecholaminergic Polymorphic Ventricular Tachycardia Panel
- ☐ Long QT Syndrome Panel
- ☐ Pan Arrhythmia Panel

Inherited Cardiomyopathies

- ☐ Arrhythmogenic Right Ventricular Dysplasia / Cardiomyopathy Panel
- ☐ Dilated Cardiomyopathy Panel
- ☐ Hypertrophic Cardiomyopathy Panel
- ☐ Pan Cardiomyopathy Panel

Other Cardiac Conditions

- ☐ Comprehensive Cardiac Panel
- ☐ Familial or Inherited Hypercholesterolemia Panel
  Specify untreated LDL-cholesterol level _____ (mmol/L)
- ☐ Inherited Lipid Disorders Panel

Connective Tissue Disorders

- ☐ Aortopathy Panel, Core
- ☐ Aortopathy Panel, Extended
- ☐ Ehlers Danlos Syndrome Panel
- ☐ Loeys-Dietz Syndrome Panel
- ☐ Osteogenesis Imperfecta Panel
- ☐ Stickler Syndrome Panel

Inherited Vascular Disorders

- ☐ Cerebral Cavernous Malformation Panel
- ☐ Hereditary Hemorrhagic Telangiectasia / Arteriovenous Malformation Panel
- ☐ Heritable Heritable Pulmonary Arterial Hypertension Panel
- ☐ Leukodystrophy and/or Porencephaly with Vascular Stroke Panel

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Section VII - Single Gene Test Request *(Complete **ONLY** if a panel is not appropriate for the patient.)*

☐ Cardiac Gene Panel, Single Gene Analysis
☐ Connective Tissue Disorder Panel, Single Gene
☐ Inherited Vascular Disorder Panel, Single Gene

Requesting test for _____ *(indicate the gene)* **and** the presenting phenotype _____

Requesting test for _____ *(indicate the gene)* **and** the presenting phenotype _____

Section VIII - Variant Reinterpretation *(Complete this section only if you are requesting reinterpretation of a variant previously identified in the family.)*

A clear copy of the test report is required if the testing was performed at another laboratory.

Gene	Mutation/Variant

What is the clinical phenotype/presentation in the family?

Section IX - Additional Comments