

Genetic Resource Centre Requisition

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

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		<input type="checkbox"/> Male <input type="checkbox"/> Non-binary	<input type="checkbox"/> Female <input type="checkbox"/> Prefer not to disclose
	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	Legacy ID	Phone	Phone
	Clinic Name			Clinic Name	Clinic Name
Collection	Date (dd-Mon-yyyy)	Time (24 hr)	Location	Collector ID	
	Genetic Counsellor/Clinical Contact Name (last, first)				Phone
Specimen					
<input type="checkbox"/> Whole blood in EDTA tube <input type="checkbox"/> Other (specify): _____					
Test Name					
<input checked="" type="checkbox"/> Genetic Resource Centre Send-Out					
Is RUSH testing needed? <input type="checkbox"/> Yes (provide details below)					
<input type="checkbox"/> Results will alter the immediate management and/or treatment of this patient					
<input type="checkbox"/> Results will impact an ongoing pregnancy (provide EDD, and procedure date if applicable): _____					
Briefly describe your patient's diagnosis and/or clinical features					
Out-of-Province Test Requested					
Is this test on the GRC Established Testing Menu					
https://www.albertahealthservices.ca/assets/wf/lab/if-lab-hc-gls-grc-established-testing-menu.pdf					
<input type="checkbox"/> No <input type="checkbox"/> Yes ► Have you completed your referral lab portal order or requisition?					
<input type="checkbox"/> No, referral lab order or requisition is pending					
<input type="checkbox"/> Yes, order placed in referral lab portal (provide order ID): _____					
<input type="checkbox"/> Yes, referral lab requisition sent to GRC (non-portal labs only)					

Last Name <i>(Legal)</i>	First Name <i>(Legal)</i>
PHN	

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Request Information Continued

Reason for testing *(check all that apply)*

- Patient clinically affected
- Presymptomatic or predictive testing
- Targeted variant testing
- Prenatal testing
- Postmortem testing
- Carrier testing and/or ethnicity screening
- Other *(specify)* _____

Is there a family history of this condition?

- No Yes ► *Specify* _____
- ▼ Has anyone else in the family had genetic testing for this condition?
- No Yes ► *Answer questions below*

How is your patient related to the index patient? _____

What is the diagnosis and/or clinical presentation of the index patient? _____

Index patient name *(Last, First)* _____

Which laboratory tested the index patient? *Please provide a copy of the index patient's report to the GRC or reference their online order number.* _____

Rationale

What is the rationale for testing? *(Check all that apply)*

- Change in therapy or management
- Cease or reduce investigation
- Impact on at risk relatives
- Prenatal diagnosis or family planning
- Other

Please provide specific details regarding your selection ***(required)***: