ALBERTA PRECISION LABORATORIES
Leaders in Laboratory Medicine

Genetics and Genomics
Cytogenetic Analysis, Constitutional 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	☐ 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

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

☐ Blood ☐ Cord Blood ☐ Amniotic Fluid ☐ Chorionic Villi ☐ Tissue, *specify* _____

☐ Other, *specify* _____ ☐ DNA Extracted from _____

Test Requested
Refer to **APL Test Directory** for test specific specimen collection, handling and transport requirements.

☐ Karyotype *(Chromosome Analysis)*
☐ FISH *(Fluorescence In Situ Hybridization)*, *specify* _____
☐ CMA *(Chromosomal Microarray)*
☐ RAD *(Rapid Aneuploidy Detection)*
☐ Culture for Alternative Testing
☐ Other, *specify* _____

Clinical Information

Sex at Birth ☐ Male ☐ Female ☐ Unknown

Family and Follow Up Studies

Previous or Concurrent Cytogenetic Testing: *(provide lab #)*

Family Members Relevant to Testing

Partner's Name		PHN
Proband's Name		PHN
Father's Name		PHN
Mother's Name		PHN
Other's Name	PHN	Relationship to Proband

Prenatal Information ☐ Fetus or Baby of Above Patient

Identifier, if multiple fetuses ☐ A ☐ B ☐ C ☐ In Utero ☐ Delivered ☐ Deceased

Gravida _____ Para _____ SA _____ TA _____ Gestational Age _____ weeks _____ days

Page 1 and Page 2 MUST be submitted with the specimen to perform testing.
By providing this requisition to the patient/family, the health care provider confirms that they have provided pre-test counselling.

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

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What is the primary indication for constitutional cytogenetic testing? ***(check all indication(s) and phenotypic descriptions that apply)***

Trisomy

- ☐ Trisomy 13
- ☐ Trisomy 18
- ☐ Trisomy 21

Sex Chromosome

- ☐ Turner syndrome
- ☐ Klinefelter syndrome
- ☐ Sex chromosome anomaly

Fertility

- ☐ Recurrent pregnancy loss
- ☐ Male or female infertility

Prenatal or Perinatal

- ☐ Nuchal translucency greater than or equal to 3.5 mm
- ☐ Positive prenatal screen
- ☐ Oligohydramnios
- ☐ Polyhydramnios
- ☐ IUGR
- ☐ 3rd or subsequent fetal loss less than 20 weeks gestation
- ☐ Fetal loss greater than or equal to 20 weeks gestation
- ☐ Stillbirth/Neonatal death
- ☐ Ultrasound abnormalities, *specify:* _____

Other Indications

Congenital Anomalies/Developmental Delay/Dysmorphic Features

Behaviour and Cognition

- ☐ Global developmental delay
- ☐ Intellectual disability ☐ Mild ☐ Moderate ☐ Severe
- ☐ Speech delay
- ☐ Autism spectrum disorder

Neurological

- ☐ Hypotonia
- ☐ Seizures
- ☐ Ataxia
- ☐ Spasticity
- ☐ Neural tube defect
- ☐ Abnormal MRI/CT
- ☐ Movement disorder, *specify:* _____
- ☐ Psychiatric disorder, *specify:* _____

Growth Parameters

- ☐ Failure to thrive
- ☐ Weight for age less than 3%
- ☐ Weight for age greater than 97%
- ☐ Stature for age less than 3%
- ☐ Stature for age greater than 97%
- ☐ Head circumference less than 3%
- ☐ Head circumference greater than 97%
- ☐ Hemihypertrophy

Cardiac

- ☐ Atrial septal defect
- ☐ Ventricular septal defect
- ☐ Atrioventricular canal defect
- ☐ Coarctation of aorta
- ☐ Tetralogy of Fallot

Respiratory

- ☐ Diaphragmatic hernia
- ☐ Lung abnormality

Craniofacial/Dysmorphic features

- ☐ Craniosynostosis
- ☐ Cleft lip/palate

Eye/Ear

- ☐ Blindness
- ☐ Coloboma
- ☐ Hypertelorism
- ☐ Deafness
- ☐ Structural outer ear anomaly(ies)

Musculoskeletal

- ☐ Upper limb abnormality
- ☐ Lower limb abnormality
- ☐ Camptodactyly
- ☐ Syndactyly
- ☐ Polydactyly
- ☐ Contractures
- ☐ Scoliosis
- ☐ Vertebral anomaly
- ☐ Club foot

Genitourinary

- ☐ Urinary tract malformation
- ☐ Hydronephrosis
- ☐ Ambiguous genitalia
- ☐ Hypospadias
- ☐ Cryptorchidism

Cutaneous

- ☐ Hyperpigmentation
- ☐ Hypopigmentation

Gastrointestinal

- ☐ Esophageal atresia
- ☐ Tracheoesophageal fistula
- ☐ Gastroschisis
- ☐ Omphalocele
- ☐ Pyloric stenosis