ALBERTA PRECISION LABORATORIES
Leaders in Laboratory Medicine

# Molecular Genetics Laboratory General 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)* ***This individual will not be copied on results*** | Phone |

**Specimen**

☐ Whole Blood in EDTA tube ☐ Extracted DNA ☐ Amniotic Fluid*
☐ 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 - Commonly Ordered Tests *(This section includes commonly ordered tests only. Complete Section VI if test requested does not appear in this section.)*

- ☐ Amyotrophic Lateral Sclerosis
- ☐ Beckwith-Wiedemann Syndrome
- ☐ Charcot-Marie-Tooth Disease
  - ☐ *PMP22* (CMT1A) dosage and sequence analysis
  - ☐ *PMP22* (CMT1A) dosage analysis only
  - ☐ *MPZ* (CMT1B) sequence and dosage analysis
  - ☐ *GJB1* (CMTX1) sequence and dosage analysis
- ☐ Congenital Adrenal Hyperplasia
  - ☐ *CYP21A2,* reflex to *CYP11B1*
  - ☐ *CYP21A2* only
  - ☐ *CYP11B1* only
- ☐ Cystic Fibrosis and / or *CFTR*-Related Disorder

  *In addition to the reason for testing indicated in Section I, indicate if testing is for the following:*
  - ☐ Fetal echogenic bowel
  - ☐ Partner with CF
  - ☐ Partner is CF carrier
  - ☐ Male factor infertility
  - ☐ Pancreatitis, bronchiectasis, sinusitis, or nasal polyps *(specify)* _____

  Sweat Chloride Value *(if applicable)*_____ mmol/L
- ☐ Copy Number Variation Analysis

  Chromosome Location _____ Variant Type _____

  Is this follow-up testing for a CMA result? ☐ No ☐ Yes *(if yes checked, provide information below)* ▼

  Index Patient Name _____ Lab Reference Number _____

  Name(s) of other family members being tested for this variant throught MGL_____

  _____
- ☐ DNA Storage - specify reason *(required)* _____
  - ☐ Short-term DNA Storage *(2 years)*
  - ☐ Long-term DNA Stroage *(25 years)* ***Must be reviewed with Lab Directors in advance.***
- ☐ *FMR1*-Related Disorder
- ☐ Frontotemporal Dementia
- ☐ Hemochromatosis, *HFE*-Related
- ☐ Maternal Cell Contamination Studies
- ☐ Myotonic Dystrophy
  - ☐ DM1 *(DMPK)* and DM2 *(ZNF9)*
  - ☐ DM1 *(DMPK)* only
  - ☐ DM2 *(ZNF9)* only

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## Section V - Commonly Ordered Tests *(continued)*

- ☐ Prader-Willi Syndrome
- ☐ Rapid Aneuploidy Detection (RAD) - *Edmonton / North Zone use ONLY; for other zones, refer to APL test directory*
- ☐ Rett Syndrome
- ☐ Spinal Muscular Atrophy
- ☐ Spinocerebellar Ataxia:
  - ☐ SCA Screen
  - ☐ SCA Specific *(indicate which type)* _____

Thalassemias and Hemoglobinopathies *(a hemoglobinopathy screen, including HPLC or electrophoresis, must be completed first unless testing is being requested on an urgent basis)*

- ☐ *HBA*-Related Disorder
  - ☐ *HBA* multiplex del-dup PCR/reflex sequencing
  - ☐ *HBA* multiplex del-dup PCR only
  - ☐ *HBA 1/2* sequencing only
- ☐ *HBB*-Related Disorder
  - ☐ *HBB* full gene analysis
  - ☐ *HBB* specific variant *(specify)*_____

- ☐ Y Chromosome Infertility

## Section VI - Other Test Selection

*For tests that do not appear in Section V (above), list the test name(s) and LABID order code(s). Refer to the APL Test Directory for test names, LABID codes, and ordering restrictions. For NGS-based tests, complete the "Cancer and Endocrine NGS Requisition" or the "Cardiac, Connective Tissue and Vascular NGS Requisition" available on the Genetics & Genomics website.*

| **LABID** ***(Required)*** | **Test Name** |
|---|---|
| | |
| | |
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| | |
| | |

## Section VII Additional Comments