Clinical Genomics Laboratory
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Halifax, NS B3K 6R8
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For additional up-to-date testing information and our most current requisitions, please visit our website:
http://www.iwk.nshealth.ca/clinical-genomics/

TEST CANCELLATION/SAMPLE DISPOSAL REQUEST

Patient Information

Name *(LAST, FIRST MIDDLE)* :

DOB *(dd/mmm/yyyy)* :

Health Card #: Province of Residence:

MRN #:

Accession #:

Phenotips ID (MMGS only):

Sex Assigned at Birth: Legal Gender:

Health Care Provider Information

Name:

Office/Institution:

Phone #: Fax # (**Required**):

Email:

Confirmation of Informed Consent: I (or my designate) have explained the risks, benefits and limits of the tests requested, and have answered the patient's questions. In my opinion the patient understands and has given informed consent for this testing.

Signature **(Required)**: _____ _____
Health Care Provider Date signed *(dd/mmm/yy)*

Sample Information

IWK Clinical Genomics Laboratory Reference Number:

☐ DNA#: _____

☐ Cytogenetic#: _____

Alternately, indicate:

Original Sample Type: _____

Date Collected, if known: _____

Additional Copies to:

Health care provider:

Facility:

Phone #: Fax #:

Test Cancellation Request

Testing will be cancelled and a report issued. *Note: Testing which has already been completed/reported cannot be cancelled*

☐ Cancel all testing on the sample(s) indicated above

☐ Cancel only the following specified test(s): _____

_____

_____

_____

Sample Destruction Request

☐ Sample Destruction Request

- I understand that I am providing consent for destruction of my sample(s) indicated above. All samples requested to be destroyed will be disposed of within 30 calendar days of the request being received in the laboratory, and a report will be issued to the Health Care Providers indicated above.
- I understand samples cannot be recovered once disposed of, and any future testing will require a new sample to be collected.
- I understand that I might have given consent for my sample to be shipped to an external laboratory. In these cases, the IWK Clinical Genomics Laboratory is unable to dispose of the sample which has already been shipped.
- I understand that data or results derived from my sample's laboratory testing are not being destroyed.

Required: **Patient/Legal Guardian Name:** _____

Patient/Legal Guardian Signature: _____ **Date:** _____