Clinical Genomics Laboratory
5850/5980 University Ave, PO Box 9700
Halifax, NS B3K 6R8
Phone: (902) 470-6504 Fax: (902) 470-7466
Email: clinicalgenomics@iwk.nshealth.ca

For additional up-to-date testing information and our most current requisitions, please visit our website:
http://www.iwk.nshealth.ca/clinical-genomics/

NEXT GENERATION SEQUENCING REQUISITION

Order as: Molecular IWK

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:

Ordering 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

- ☐ Peripheral blood - Lavender **EDTA** 3mL (newborns <1 month: 1mL)
- ☐ Cord blood — see reverse for collection. A **maternal EDTA blood sample** is also required
- ☐ Postmortem blood — Lavender EDTA 3mL ☐ Tissue — Specify: _____
- ☐ Skin biopsy (culture, then extract DNA) ☐ DNA#: _____
- ☐ Skin biopsy (direct DNA extraction) ☐ Cultured cells: _____

Collection Date/Time:

Collection Facility: **Collector Initials:**

Indicate if the Patient has:

- ☐ Had an allogeneic bone marrow transplant
- ☐ A current hematological neoplasm
- ☐ Received blood products containing leukocytes/non-irradiated RBCs in ≤14 days

Additional Copies to:

Health care provider:

Facility:

Phone #: Fax #:

Clinical Information and Family History

Clinical Findings Required: As detailed as possible and/or attach clinic notes.

Include previous genetic and non-genetic investigations. (Or, submit Phenotips ID)

_____

_____

_____

_____

Indication and Reason for Testing

Request for Expedited Result:

- ☐ Results impact a pregnancy management decision: indicate EDC _____
- ☐ Medical intervention: specify, include date _____
- ☐ Other: specify _____

Testing Category: Required

- ☐ Diagnostic testing (symptoms of disease/disorder) — **describe in Clinical Info section**
- ☐ Predictive testing (documented family history) — by Medical Genetics only
- ☐ Carrier testing
- ☐ Other: _____

Testing Requested

Sequencing*: complete clinical phenotype and family history/pedigree must be provided

- ☐ Panel: _____
- ☐ Gene(s): _____

*refer to iwkhealth.ca/CGL/TestMenu for available genes, panels, and testing restrictions

Known Variant Testing: Include proband report when possible

- ☐ Copy number variant (CNV) ☐ Sequence variant

(HGVS/ISCN): _____

Required: Proband Name/DOB: _____

HCN/IWK DNA#: _____ Relationship to patient: _____

DNA Storage:

- ☐ **Extract & Hold (5 year retention):** Testing likely to follow within 5 years
- ☐ **Irreplaceable Storage (25 year retention):** Testing likely to follow beyond 5 years ***AND*** sample cannot be recollected

Pedigree/Family History:

Consanguinity: specify _____

Ethnic Background: ☐ Acadian ☐ Ashkenazi Jewish ☐ Indigenous ☐ French Canadian ☐ Hispanic ☐ African ☐ European Caucasian ☐ Asian ☐ Middle Eastern ☐ Other

Please see reverse page for collection information and shipping instructions