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 | Legacy 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)* | Phone |

☐ 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**

1. All sections of the requisition must be completed.
2. 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.
3. 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 | Rec'd | 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 of Indicated Disease**

☐ Unknown family history

☐ No known family history

☐ Possible family history

**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 (provide details below)

Family Member Name(s): _____

MGL Reference Number(s): _____

**Is RUSH testing needed?** ☐ Yes *(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: _____

Has the patient had a bone marrow transplant? ☐ Yes **(Blood is an incompatible specimen type.)**

Please 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 *CYB11B1*
- ☐ *CYP21A2* only
- ☐ *CYB11B1* only

☐ Cystic Fibrosis and / or *CFTR*-Related Disorder

In addition to the reason for testing indicated in Section I, indicate if testing is for:
- ☐ Fetal echogenic bowel
- ☐ Partner with CF
- ☐ Partner 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, 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) _____

☐ *FMR1*-Related Disorder

☐ Frontotemporal Dementia

☐ Genetics Send Out *(if Genetic Resource Centre funding is needed for this patient, complete the Genetic Resources Centre requisition instead, available on the Genetics & Genomics website)*

Specify out-of-province genetic test: _____

Index patient name and date of birth or PHN, if applicable *(ex. if trio test):*

☐ Hemochromatosis, *HFE*-Related

☐ Maternal Cell Contamination Studies

☐ Myotonic Dystrophy:
- ☐ DM1 *(DMPK)* and DM2 *(ZNF9)*
- ☐ DM1 *(DMPK)* only
- ☐ DM2 *(ZNF9)* only

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- ☐ Non-Syndromic Hearing Loss
- ☐ 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 no 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 |
|---|---|
| | |
| | |
| | |
| | |
| | |

**Section VII Additional Comments**