DIAGNOSTIC SERVICES OF MANITOBA
SERVICES DE DIAGNOSTIC DU MANITOBA

MS5 Thorlakson Building
820 Sherbrook Street
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Phone: (204) 787-1534 Fax: (204) 787-3473

MOLECULAR DIAGNOSTIC LABORATORY TEST REQUISITION

***** PLEASE COMPLETE THE INFORMATION BELOW, PRINT CLEARLY *****

NAME OF PHYSICIAN ORDERING TEST: .... (LAST) (FIRST)

REFERRING INSTITUTION NAME AND ADDRESS OR CODE (FOR NON-HSC LOCATIONS):

FOR AN ADDITIONAL COPY OF REPORT, COMPLETE THE FOLLOWING:

NAME OF PHYSICIAN: .....

ADDRESS: .....

CITY: ..... **PROV.** ..... **POSTAL CODE** .....

TELEPHONE NO. ..... **FAX NO.** .....

ENCOUNTER NO.: ..... LOCATION (WARD/CLINIC): .....

PATIENT NAME: .... (LAST) (FIRST)

DATE OF BIRTH: ..... (DD/MMM/YYYY) SEX: ☐ F ☐ M

FACILITY PATIENT ID NO.: .....

PROVINCIAL HEALTH NUMBER (9 DIGITS): .....

PHYSICIAN/PHYSICIAN NO.: .....

COLLECTION DATE: .....

COLLECTION TIME: .....

COLLECTED BY: .....

SPECIMEN ID # HSC LAB USE ONLY

CLINIC/LABORATORY CONTACT:

NAME: .....

TELEPHONE NO. .....

FAX NO. .....

FOR HSC LAB USE ONLY

DNA # .....

DELPHIC BARCODE LABEL

MOLECULAR TESTING

I. Test Requested

☐ Angelman Syndrome	MD
☐ Ashkenazi Jewish Panel	MD
☐ CADASIL (NOTCH 3)	MD
☐ Charcot-Marie-Tooth Type 1A	MD
☐ Cystic Fibrosis (ethnic background required)	MD
☐ DNA Banking	MD
☐ Fragile X	MD
☐ Hereditary Neuropathy with Liability to Pressure Palsies	MD
☐ Hereditary Non-Syndromic Hearing Loss (GJB2 & GJB6) (ethnic background required)	MD
☐ Huntington Disease	MD
☐ Kennedy Disease	MD
☐ Myotonic Dystrophy Type 1 (ethnic background required)	MD
☐ Oculopharyngeal Muscular Dystrophy	MD
☐ Prader-Willi Syndrome	MD
☐ Sex Determination	MD
☐ Spinocerebellar Ataxia Types 1, 2, 3, 6, 7, 8	MD
☐ Y Chromosome Microdeletions	MD
☐ Other _____	MD
☐ Apo E ☐ MTHFR	MD
☐ Hereditary Hemochromatosis (reason for testing required)	MD
Fetal Blood Grouping ☐ RhD ☐ KELL ☐ PLA1	MD

Samples Required

ONE OF THE FOLLOWING:

- ☐ Blood 10 mL EDTA
- ☐ Blood (infant only) 3 mL EDTA
- ☐ Cultured Amniocytes * (Maternal sample required)
- ☐ Amniotic Fluid * 5 mL (Maternal sample required)
- ☐ Other _____

* *Lab consult required for prenatal diagnosis*

- ☐ Blood 5 mL EDTA
- ☐ Amniotic Fluid 5 mL (Maternal sample required)

II. Reason for Test **

** *May require prior genetic consultation before proceeding with testing*

- ☐ Confirmation of Clinical Diagnosis
- ☐ Carrier Status
- ☐ Predictive Testing
- ☐ Prenatal Diagnosis LMP _____
- ☐ Other _____

III. Clinical Information and Family History

*Testing will **NOT** be initiated without this information*

Other family members sent previously: ☐ Yes ☐ No

INDEX PATIENT NAME: _____

*** Please send all samples at **ROOM TEMPERATURE** ***

Ship samples to: HSC, Department of Clinical Biochemistry & Genetics, Room MS-551, 820 Sherbrook Street, Winnipeg, MB, CANADA R3A 1R9

For test information & sample requirements please go to: http://www.dsmanitoba.ca/ , choose “Info for Professionals” and click on **DSM LIM – Winnipeg Sites**