400 University Avenue, Saint John, NB, E2L 4L2

Cytogenetics Laboratory:
Saint John Regional Hospital

Tel: (506) 648-6882,
Fax: (506) 649-2536

Hours of operation: Monday to Friday 08:00 - 16:30

CONSTITUTIONAL CYTOGENETICS REQUISITION

For Booking Appointments Please Provide Local Blood Collections Phone #: ______________________________

☐ **STAT**

Patient Information

Name: ____

Date of Birth: (Month/DD/YYYY): ______________________

Sex: ☐ M ☐ F ☐ Unknown

NB Medicare#: ________________________ Expiry: ________

Other Insurance/Client #: ______________________________

Ordering Physician Information

Name (Please Print): __________________________________

Signature (Required): _________________________________

Address: ____

____

Phone #: ___________________ Fax #: ____________________

Copy to: ____

Sample Requirements

☐ Peripheral Blood (Room Temp.)
3.0 mL minimum in a Sodium Heparin tube

☐ Cord Blood (Room Temp.)
1.0 mL minimum in a Sodium Heparin tube

☐ Other: (Please call laboratory for handling instructions)

Collection Information

Collection date (Month/DD/YYYY): ______________________

Time: _________ Collection Facility: ___________________

Referring Specimen ID: ______________________________

Samples are shipped at room temperature within 24 hours of collection. Samples are to ARRIVE during operating hours before NOON on Fridays.
DO NOT CENTRIFUGE or FREEZE SAMPLES

Is this constitutional analysis to rule out the possibility of an incidental finding from a previous cancer study?
If YES, disregard the remainder of the requisition.

☐ YES ☐ NO

Specific Indications

Clinical Features of:
- ☐ Down Syndrome
- ☐ Trisomy 13
- ☐ Trisomy 18
- ☐ Turners
- ☐ Klinefelter
- ☐ Other: _______________
____

FISH for:
- ☐ VCF/DiGeorge Syndrome
- ☐ SRY
- ☐ Other: _______________
____

Non- Specific Indications

- ☐ Still Birth
- ☐ Neonatal Death
- ☐ Dysmorphic Facies
- ☐ Developmental Delay
- ☐ Behavioural Problems
- ☐ Psychiatric Illness
- ☐ Multiple Congenital Anomalies
- ☐ Short Stature
- ☐ Ambiguous Genitalia
- ☐ Amenorrhea
- ☐ >3 Miscarriages #: _____

Currently Pregnant? **Y / N**
Gestation: ____ **weeks** ____ **days**

- ☐ Azoospermia/ Oligospermia
- ☐ Family History

Provide Clinical Details and/or Pedigree:
Previous or concurrent testing on relative/partner? Name and DOB (Month/DD/YYYY) or Report
Name: ______________________________________ **DOB:** ____________________

Proband: ____________________________ Relation to Proband: ________________________

Affix SJRH Label

Do not write in this space

(Revised: 2018/12)