



**NORTH  
YORK  
GENERAL**

*Making a World  
of Difference*

# Microarray Requisition

## Genetics Laboratories

4001 Leslie Street 3SE-186, Toronto, ON M2K 1E1  
Phone: (416) 756-6791 Fax: (416) 756-6197

[www.nygh.on.ca/genetics/labs](http://www.nygh.on.ca/genetics/labs)

*Patient information/Place Stamp Here*

**Patient Name** \_\_\_\_\_  
(Last) (First)

**Male**  **Female**  **DOB** \_\_\_\_\_  
(YYYY/MM/DD)

**Health Card#** \_\_\_\_\_

**Address** \_\_\_\_\_

The DNA extracted from the patient's specimen (blood or tissues) will be destroyed one year after the test is reported. Some residual specimens may be used anonymously in the lab for test development or quality assurance purposes. If the patient wishes to waive the usage of his/her specimen by the lab, please sign here \_\_\_\_\_, Date \_\_\_\_\_

**Specimen Collection Centre:**

**Collection Date (yy/mm/dd):**

### Specimen Type:

- Blood in EDTA (3 mL minimum or 1 mL for pediatric samples)
- Other (specify): \_\_\_\_\_

**Expedited testing:** Yes No **Gestation (if applicable)** \_\_\_\_\_ weeks

### Indications for Testing:

- Developmental delay
- Intellectual disability
- Autism
- PLUS the following clinical features (please list):

\_\_\_\_\_

- Two or more congenital anomalies (please list):

\_\_\_\_\_

- Other (specify): \_\_\_\_\_

### Other relevant family information/karyotype, if known / previous microarray (include report):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Report to: (Physician Information)

Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Province/Postal Code \_\_\_\_\_

Signature \_\_\_\_\_

Cc:

Name: \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

Fax (\_\_\_\_) \_\_\_\_\_

### LAB USE ONLY

LAB #: \_\_\_\_\_ Date Rec'd: \_\_\_\_\_

Chart Checked by: \_\_\_\_\_

# Sample Requirements

## Requisition

Complete this Microarray Requisition completely including;

- Patient information: patient's name, date of birth, gender, address and Ontario Health Card number
- Specimen information: specimen type, where collected and when collected
- Indications for testing
- Referring physician name, address, phone and fax numbers, and signature
- Indicate if Expedited testing is required
  - Criteria for Expedited testing:      Newborn  $\leq$  1 month of age
  - Ongoing pregnancy in family
- Any other relevant information

## Sample Requirements

- *Peripheral blood*: 3 mL minimum collected in EDTA tube
- *Extracted DNA from peripheral blood*: 1  $\mu$ g minimum
- Label specimen tubes with the individual's first and last names and date of birth

### ***Please note:***

- ***Specimens received for testing in the incorrect anti-coagulant will be rejected.***
- ***Blood specimens in patients who have had a allogenic transplant (bone marrow or stem cell) will not be accepted.***

## Shipping Instructions

- Ship specimens at **room temperature** by overnight courier such that the specimen arrives in the Laboratory Monday to Friday
- Specimens held for a few days prior to shipping should be maintained at 4°C
- When shipping blood specimens, follow the regulations of the Transportation of Dangerous Goods Act (1992, C.34)

***Specimens must arrive in the Laboratory within seven (7) days of collection date.***