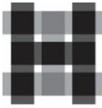

NORTH YORK GENERAL
Making a World of Difference

Microarray Requisition

Genetics Laboratories

4001 Leslie Street 3SE-186, Toronto, ON M2K 1E1
Phone: (416) 756-6240 Fax: (416) 756-4729
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)
- ☐ DNA from peripheral blood (1 µg)
- ☐ Saliva (Oragene collection only)
- ☐ Other (specify): ______________________________

Expedited testing: Yes No Gestation (if applicable)_________weeks

Indications for Testing:

- ☐ Developmental delay
- ☐ Intellectual disability
- ☐ Autism spectrum disorder (ASD)
- ☐ 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 Date Received:

Lab ID Label: Chart Checked by: _________________

Requirements

NYGH Genetics Laboratories Terms & Conditions can be found on our website at https://www.nygh.on.ca/areas-care/genetics/genetics-forms-and-additional-information.
These Terms & Conditions must be reviewed prior to placing an order.

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 ≤ 1 month of age
  Ongoing pregnancy in family
- *Any other relevant information*

Sample Requirements

- Minimum quantity of sample required is indicated on the requisition.
- 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 from patients who have had a blood transfusion will be accepted three weeks post transfusion.***
- ***Blood specimens from patients who have had an 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 between 8:30 and 4:30 pm
- Specimens held for a few days prior to shipping should be maintained at 4ºC
- When shipping blood specimens, follow the regulations of the Transportation of Dangerous Goods Act (1992, C.34)