REQUISITION – Prenatal and Perinatal Microarray

Hamilton Regional Laboratory Medicine Program

Juravinski Hospital
Clinical Genetics Laboratory - Room H2-19A
711 Concession Street, Hamilton, ON L8V 1C3
Phone: (905) 521-2100 x73707
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Patient Information

Clear Form

*__Name__ (print):
Surname, First Name
*__DOB__ (DD/MM/YYYY):
*__Sex__: ☐M ☐F ☐Other
*__Health Card No.__:

**Mandatory Information. Specimen cannot be processed without this data.*

Note: Specimen collection is NOT completed at this lab. Please proceed to any community lab for blood draw.

Reports To:

*Ordering Physician: _____
*Address: _____
*Phone: _____ *Fax: _____
*Email: _____
*Authorized Signature: _____

Additional Copies To:

*Name: _____
*Address: _____
*Phone: _____
*Fax: _____
*Email: _____

Please see the HRLMP Laboratory Test Information Guide (LTIG) for complete sample requirements and test information:
https://ltig.hrlmp.ca/

SPECIMEN INFORMATION: Transport at room temperature to the above address.

❑ Amniotic fluid (15-20 cc) ❑ Chorionic villi sample (>10 mg) ❑ Other: _____

❑Perinatal tissue (products of conception, umbilical cord, fetal skin) * **placental tissue is NOT accepted**

* A maternal peripheral blood sample must be submitted with all samples for Maternal Cell Contamination (MCC) Studies. Please use the Cytogenetic (other than cancer) Requisition for MCC samples.

Please Note: Prenatal microarrays are assessed at a lower resolution that postnatal arrays, contact the laboratory directly at geneticsmailbox@hhsc.ca if a higher resolution analysis is required.

Collection Date (DD/MM/YY):
_____
Collection Time: _____
Testing Priority:
❑ Routine ❑ Urgent
Is a pregnancy at risk?
❑ No ❑ Yes, GA: _____ wks

CLINICAL INFORMATION: Please check all that apply.

Perinatal History:
[ ] IUGR
[ ] Oligohydramnios
[ ] Polyhydramnios
[ ] Increased nuchal translucency (includes cystic hygroma)
[ ] 2 vessel cord
[ ] Other: _____

Neurological:
[ ] Neural tube defect (myelomeningocele)
[ ] Agenesis of the corpus callosum
[ ] Dandy Walker (posterior fossa abnormality)
[ ] Ventriculomegaly/ hydrocephaly
[ ] Decreased fetal movement
[ ] Abnormal gyri (lissencephaly)
[ ] Structural brain anomaly
[ ] Cerebellar hypoplasia
[ ] Other: _____

Craniofacial:
[ ] Cleft lip
[ ] Cleft palate
[ ] Hyper/hypotelorism
[ ] Absent nasal bone
[ ] Macro/microcephaly
[ ] Other: _____

Cardiac:
[ ] Atrial/ Ventricular Septal Defect (ASD/VSD)
[ ] Atrioventricular Canal Defect
[ ] Coarctation of the aorta
[ ] Hypoplastic heart (left/right)
[ ] Tetralogy of Fallot
[ ] Echogenic intracardiac focus
[ ] Dextrocardia or situs inversus
[ ] Double outlet right ventricle
[ ] Transposition of the great vessels
[ ] Truncus arteriosus
[ ] Pulmonary valve atresia
[ ] Aortic atresia
[ ] Ebstein anomaly
[ ] Other: _____

Gastrointestinal:
[ ] Gastroschisis/Omphalocele
[ ] Absent/small stomach
[ ] Echogenic bowel
[ ] Other: _____

Thorax:
[ ] Congenital pulmonary adenomatoid malformation (CPAM)
[ ] Diaphragmatic hernia
[ ] Pleural effusion
[ ] Other: _____

Musculoskeletal:
[ ] Contractures (arthrogryposis)
[ ] Club foot
[ ] Polydactyly
[ ] Syndactyly
[ ] Clenched hands
[ ] Micromelia
[ ] Other limb/digit anomaly
Specify: _____
[ ] Scoliosis
[ ] Vertebral anomaly
Specify: _____
[ ] Other: _____

Genitourinary:
[ ] Ambiguous genitalia
[ ] Hydronephrosis
[ ] Renal agenesis (unilateral/ bilateral)
[ ] Polycystic kidneys
[ ] Lower urinary tract obstruction
[ ] Other: _____

Family History:
[ ] Parents with ≥ 3 miscarriages
[ ] Other relatives with similar clinical history
Explain: _____

Other Relevant Clinical Findings: _____

Known Consanguinity: (Y/N), specify _____ **Isolated population ancestry** (Y/N), specify _____ **Homozygosity Information NOT Requested** [ ]*

*This assay can detect regions of homozygosity suggestive of consanguinity. Only use this box if this information is NOT requested.

LAB USE ONLY Tech: Lab No: Received: Specimen Comments: