

MOLECULAR DIAGNOSTICS LABORATORY

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Molecular Hematology, Oncology and Pathology

3175, Côte Sainte-Catherine, Montréal, QC, H3T 1C5, 514-345-4931

Requesting Institution/Unit : _____ Address : Civic number _____ Street _____ City _____ Province/Country _____ Postal code _____ Phone : _____ FAX: _____ Referring physician : _____ Licence No : _____ Sampling Date : _____ Time _____ Sampled by : _____	Patient information Last name: _____ First name: _____ Gender: F <input type="checkbox"/> M <input type="checkbox"/> Medical records number / Provincial health number: _____ Date of birth: _____
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Clinical information: _____
 I certify that I have explained the following to the patient: the nature of the requested test, its benefits, limitations and potential risk for the patient and his or her family. I certify that I have obtained signed informed consent for the test from the patient or his or her legal guardian.

SAMPLE TYPE

- | | |
|--|---|
| <input type="checkbox"/> EDTA Blood : 5ml (EDTA vial) _____ # of tubes | <input type="checkbox"/> Filter (Guthrie) card filled with EDTA blood |
| <input type="checkbox"/> Amniocytes | <input type="checkbox"/> Paraffin sample : # _____ |
| <input type="checkbox"/> Bone marrow (EDTA vial) | <input type="checkbox"/> Tissue : _____ |
| <input type="checkbox"/> Chorionic villi | <input type="checkbox"/> Other : _____ |
| <input type="checkbox"/> Cultured chorionic villi (T25 flask(s)) | |
| <input type="checkbox"/> DNA : _____ (specify origin aside from blood) | |

ANALYSIS REQUESTED

- | | |
|--|--|
| <input type="checkbox"/> Alveolar rhabdomyosarcoma t(1;13), t(2;13) ¹
<input type="checkbox"/> Burkitt lymphoma t(8;14) ²
<input type="checkbox"/> Chimerism, pre-transplant
<input type="checkbox"/> Chimerism, post-transplant
<input type="checkbox"/> Congenital fibrosarcoma t(12;15) ETV6/NTRK3 ¹
<input type="checkbox"/> Desmoplastic small round cell tumor t(11;22) EWSR1/WT1 ¹
<input type="checkbox"/> Diffuse large B-cell lymphoma t(2;5) NPM1/ALK ¹
<input type="checkbox"/> DNA extraction, please justify : _____
<input type="checkbox"/> Ewing sarcoma t(11;22) EWSR1/FLI-1; t(21;22) EWSR1/ERG ¹
<input type="checkbox"/> GATA2 : Sequencing (coding exons)
<input type="checkbox"/> Panel for acute megakaryocytic leukemia : ¹
<input type="checkbox"/> t(1;22) RBM15-MKL1 <input type="checkbox"/> t(1;12) NUP98-JARID1A <input type="checkbox"/> INV(16) CBFA2T3-GLIS2
<input type="checkbox"/> Panel for acute lymphoblastic leukemia : ¹
<input type="checkbox"/> t(9;22) <input type="checkbox"/> t(12;21) <input type="checkbox"/> t(1;19) <input type="checkbox"/> t(4;11)
<input type="checkbox"/> Panel for non-lymphoblastic leukemia : ¹
<input type="checkbox"/> inv(16) <input type="checkbox"/> t(9;11) <input type="checkbox"/> t(15;17) <input type="checkbox"/> t(8;21)
<input type="checkbox"/> Panel for MLL leukemia : ¹
<input type="checkbox"/> t(1;11) <input type="checkbox"/> t(6;11) <input type="checkbox"/> t(10;11) <input type="checkbox"/> t(4;11) <input type="checkbox"/> t(9;11)
<input type="checkbox"/> t(11;19) MLL/ENL <input type="checkbox"/> t(11;19) MLL/ELL
<input type="checkbox"/> Other translocations : ¹
<input type="checkbox"/> t(5;11) NUP98-NSD1 <input type="checkbox"/> t(6;9) DEK-NUP214 <input type="checkbox"/> t(9;9) PAX5-JAK2
<input type="checkbox"/> t(11;17) MLL-LASP1 <input type="checkbox"/> t(10;11) PICALM-MLLT10
<input type="checkbox"/> PAX5 : Sequencing (coding exons)
<input type="checkbox"/> RUNX1/AML1 : Sequencing (coding exons)
<input type="checkbox"/> TP53 : Sequencing (coding exons)
<input type="checkbox"/> Other : _____ | <input type="checkbox"/> Alpha Thalassemia, deletions 3.7, 4.2, MED, SEA, FIL, THAI, 20.5
<input type="checkbox"/> Angioedema
<input type="checkbox"/> Hemoglobinopathy C
<input type="checkbox"/> Hemoglobinopathy S
<input type="checkbox"/> Hemophilia A (Factor VIII)
<input type="checkbox"/> Hemophilia B (Factor IX)
<input type="checkbox"/> Factor V Leiden R506Q
<input type="checkbox"/> Factor VII Deficiency
<input type="checkbox"/> Fetomaternal contamination detection
<input type="checkbox"/> MTHFR C677T
<input type="checkbox"/> Protein C Deficiency
<input type="checkbox"/> Prothrombin G20210A
<input type="checkbox"/> Quebec Platelet Disorder
<input type="checkbox"/> Von Willebrand Type 2, specify _____
<input type="checkbox"/> Other : _____
<input type="checkbox"/> Cerebral tumor (H3F3A : p.K27M and p.G34V/R; HIST1H3B : p.K27M)
<input type="checkbox"/> Fragile X syndrom
<input type="checkbox"/> Muscular dystrophy analysis by western blot :
Ac dystrophin, Ac calpain and Ac dysferlin |
|--|--|

FAMILY INFORMATION

Relationship with index case : _____
 Index case name : _____
 Additional sample sent for this family : _____
 Family # : _____
 Justification for requested test : _____

SAMPLE RECEPTION

Laboratoire Central
 CHU Sainte-Justine
 2nd floor, bloc 9
 3175, Côte Sainte-Catherine
 Montréal (Québec) H3T 1C5
 Phone : 514-345-4642 Fax : 514-345-2339

PEDIGREE

1 : RT-PCR 2: PCR