

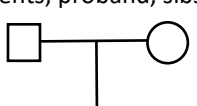
#317, 3655 – 36 Street NW  
 Calgary, AB T2L 1Y8  
 403-284-0039 [info@discoverydna.ca](mailto:info@discoverydna.ca)

By providing this requisition to the patient/family, the health care provider confirms that they have reviewed and discussed the pre-test counselling information with the patient/family and the patient/family consents to testing.

<b>Patient</b>	PHN	Alternate Identifier	Date of Birth (yyyy-mm-dd)		Gender <input type="checkbox"/> M <input type="checkbox"/> F
	Last Name		First Name	Middle Initial	Ph H: C:
	Address		City/Town	Prov	Postal Code
<b>Requestor</b>	Requestor Name		Copy to <i>(last, first Name)</i>		
	Location/Facility Address		Location/Facility Address		
	Phone	FAX	Phone	FAX	
	Requestor/Referring Centre ID				

Order Information - Only those samples with completed forms and correct/complete labelled samples will be accessioned. Samples which yield sufficient DNA will proceed to testing. Results will only be provided if all relevant sections of the requisition are completed.

<b>Collection information</b>	Date (yyyy-mm-dd)	Time collected (24 h)	Collector Name / ID	Location
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<p><b>SPECIMENS</b>                  Refer to our website SPECIMEN DETAILS section for information on requirements  <a href="http://www.discoverydna.ca">www.discoverydna.ca</a></p> <p><input type="checkbox"/> Saliva - <input type="checkbox"/> assisted <input type="checkbox"/> non-assisted <input type="checkbox"/> oral sponge  <input type="checkbox"/> other _____</p> <p><input type="checkbox"/> Tissue - Anatomic Site _____</p> <p><input type="checkbox"/> Recent Transfusion / Transplant                  Date if known: _____</p> <p><input type="checkbox"/> Your Reference #: _____</p> <p><input type="checkbox"/> Ethnic Background: _____</p>	<p><b>FAMILY HISTORY</b>                  Other family members tested previously?  <input type="checkbox"/> Yes <input type="checkbox"/> NO                  Index Patient Name: _____</p> <p>_____</p> <p>Please complete the pedigree indicating names of parents, proband, sibs and children.</p> <div style="text-align: center;">  </div>	<p><b>TEST REQUESTED</b></p> <p><input type="checkbox"/> WES - Whole Exome Study  <input type="checkbox"/> WGS - Whole Genome Study  <input type="checkbox"/> Mitochondrial Studies  <input type="checkbox"/> Reanalysis  <input type="checkbox"/> PGX – preferred ON-600 kit non-assisted  <input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> RAPID TAT Requested (&lt; 2 weeks)                  Note: Unforeseen situations may occur that may prohibit us from achieving the rapid TAT.</p>
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<p><b>INDICATION</b> (Check all relevant boxes)</p> <p><input type="checkbox"/> Confirmation of clinical diagnosis  <input type="checkbox"/> Carrier Status  <input type="checkbox"/> Presymptomatic Testing  <input type="checkbox"/> Documented family history of indicated disease  <input type="checkbox"/> Possible family history of indicated disease  <input type="checkbox"/> Required for family study (no report)  <input type="checkbox"/> Store sample until further notice</p>	<p><b>HPO TERMS / Clinical Features / Comments</b></p>
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<p><b>Accession Checklist</b> <i>(lab only)</i></p> <p>Form complete/correct? Yes <input type="checkbox"/> No <input type="checkbox"/>                  Is this a rapid request? Yes <input type="checkbox"/> No <input type="checkbox"/>                  Request Type: Clinical <input type="checkbox"/> Private <input type="checkbox"/></p>	<p style="font-size: 1.2em; color: #808080;">Place Laboratory LIS Collection &amp; Transfer Labels Here</p>
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