**Molecular Genetics Laboratory**
BC Children's Hospital & BC Women's Hospital
2J40 - 4500 Oak Street, Vancouver, BC V6H 3N1
Phone (604) 875-2852 • Fax (604) 875-2707
• moleculargenetics@cw.bc.ca • www.genebc.ca
• Facility Code L1050

# Request for Shipment

## Out-of-Province/Out-of-Country Genetic Testing

**To:** Molecular Genetics Laboratory (MGL)

**Fax:** 604-875-2707

**Phone:** 604-875-2852

| | |
|---|---|
| **From:** | |
| **Fax:** | |
| **Date:** | |
| **# Pages:** | |

**COMPLETE FOR EACH SAMPLE & EACH REFERRAL LABORATORY**

### PRIORITY

☐ **STAT** (affects pregnancy management)

EDD: _____
DD/MMM/YY

☐ **ROUTINE**

### SAMPLE TYPE

☐ **BLOOD**

☐ **TISSUE**; Surgical Path #: _____

☐ **DNA***; MGL Sample ID: _____
*prior approval required, as per policy

Quantity: _____ ug OR _____ ug/ul & _____ ul

### MEDICAL GENETICS ONLY:

**CVS OR AMNIOCENTESIS:**

☐ DNA ☐ Cultured ☐ Uncultured*
*consultation required

**SPECIAL INSTRUCTIONS:** (quantity, # flasks, etc.)

_____

### REQUESTOR INFORMATION

| Ordering Physician Last Name | Ordering Physician First Name |
|---|---|
| | |
| Contact Person (if differs from Ordering Physician) | |
| | |
| Contact Phone Number (if differs from above) | |
| | |

### PATIENT INFORMATION

| Last Name | First Name |
|---|---|
| | |
| Personal Health Number | Date of Birth (DD/MMM/YY) |
| | |
| Gender | Referring Clinic ID |
| ☐ M ☐ F ☐ UNK | |

### REFERRAL LABORATORY & TEST INFORMATION

| Referral Laboratory | Disorder or Test Requested |
|---|---|
| | |
| Shipping Address: | |
| | |

### CHECKLIST:

☐ Provincial Laboratory Medicine Services Agreement and Consent for Out of Province testing form

☐ Referral Lab paperwork
☐ Provide Funding Details:

### MGL USE ONLY

SHIPMENT

LABEL

CM_PW ☐