

Molecular Genetics Laboratory

BC Children's Hospital & BC Women's Hospital
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 • Facility Code L1050

Request for Shipment Out-of-Province 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	SAMPLE TYPE	
<input type="checkbox"/> STAT (affects pregnancy management) EDD: _____ <small>DD/MMM/YY</small> <input type="checkbox"/> ROUTINE	<input type="checkbox"/> BLOOD <input type="checkbox"/> TISSUE ; Path #: Á _____ <input type="checkbox"/> DNA* ; MGL Sample ID: _____ <small>*prior approval required, as per policy</small> Quantity: _____ ug OR _____ ug/ul & _____ ul	MEDICAL GENETICS ONLY: CVS OR AMNIOCENTESIS: <input type="checkbox"/> DNA <input type="checkbox"/> Cultured <input type="checkbox"/> Uncultured* <small>*consultation required</small> SPECIAL INSTRUCTIONS: (quantity, # flasks, etc.) _____

REQUESTOR INFORMATION		PATIENT INFORMATION	
Ordering Physician Last Name	Ordering Physician First Name	Last Name	First Name
Contact Person (if differs from Ordering Physician)		Personal Health Number	Date of Birth (DD/MMM/YY)
Contact Phone Number (if differs from above)	Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> UNK		Referring Clinic ID

REFERRAL LABORATORY & TEST INFORMATION	
Referral Laboratory	Disorder or Test Requested
Shipping Address:	

CHECKLIST:	MGL USE ONLY
<input type="checkbox"/> MSP funding approval letter <input type="checkbox"/> Referral lab paperwork (requisition, consent form, etc) <input type="checkbox"/> Consent to Release Information Form (Bill 73 consent)** <small>** Only required for shipment outside of Canada</small>	SHIPMENT LABEL CM_PW <input type="checkbox"/>

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