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 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**; 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:

- ☐ MSP funding approval letter
- ☐ Referral lab paperwork (requisition, consent form, etc)
- ☐ Consent to Release Information Form (Bill 73 consent)**
  ** Only required for shipment outside of Canada

MGL USE ONLY

SHIPMENT
LABEL

CM_PW ☐

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PRINT FORM | CLEAR ALL FIELDS | CLEAR PATIENT & LAB FIELDS | CLEAR PATIENT FIELDS