ALBERTA PRECISION LABORATORIES
Leaders in Laboratory Medicine

Molecular Genetics Laboratory
Cardiac, Connective Tissue and Vascular NGS Requisition

*For detailed testing information, refer to **APL Genetics & Genomics Webpage** (**http://ahsweb.ca/lab/if-lab-genetics-and-genomics**) and **APL Test Directory** (**http://ahsweb.ca/lab/apl-td-lab-test-directory**)*

Scanning Label or Accession # *(lab only)*

Patient

PHN Expiry: _____		Date of Birth *(dd-Mon-yyyy)*		
Legal Last Name		Legal First Name	Middle Name	
Alternate Identifier	Preferred Name	☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to disclose	Phone	
Address		City/Town	Prov	Postal Code

Provider(s)

Authorizing Provider Name *(last, first, middle)*			Copy to Name *(last, first, middle)*	Copy to Name *(last, first, middle)*
Address		Phone	Address	Address
CC Provider ID	CC Submitter ID	Legacy ID	Phone	Phone
Clinic Name			Clinic Name	Clinic Name

Collection

Date *(dd-Mon-yyyy)*	Time *(24 hr)*	Location	Collector ID

Genetic Counsellor/Clinic Contact Name *(last, first)*	Phone

Specimen

☐ Whole Blood in EDTA tube ☐ Extracted DNA ☐ Fluid, amniotic*

☐ Tissue, chorionic villi* ☐ Cord blood* ☐ Other *(specify):* _____

*If specimen type is prenatal or cord blood, maternal specimen must be collected for maternal cell contamination studies

Health Care Provider Important Information

1. All sections of the requisition must be completed.
2. By providing this requisition to the patient/family, the health care provider confirms that they have reviewed the pre-test counselling information (available on the Genetics & Genomics website) with the patient/family, and the patient/family consents to testing.
3. Direct patient to take requisition to a local blood collection location to have blood specimen drawn.

Billing Information: Must be completed if the patient does not have a valid Alberta Personal Heath Number

Genetic testing is not covered by inter-provincial billing agreements. Alberta Precision Laboratories (APL) will bill a provincial medical services plan provided there is a letter of pre-approval received with the requisition or Institutional Billing information provided below. By completing the Institutional Billing section, the health care provider confirms they have obtained any necessary pre-approval. For patient pay, contact the testing laboratory.

Institutional Billing Information *(if pre-approval letter not attached)*	
Address	
Contact Name *(last, first)*	
Phone	Fax

MGL Use Only

Patient Number	Family Number	Rec'd	Quantity

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Section I - Reason for Testing *(Select one only)*

☐ **Confirmation of Diagnosis**.
Patient has signs or symptoms of the disease / disorder.

☐ **Presymptomatic or Predictive Testing**.
Patient does not presently have symptoms; positive family history

☐ **Carrier Testing**.
No symptoms; at risk of being a carrier of a recessive disorder

☐ **Required for Family Study**.

☐ **Prenatal Testing**

☐ **Other** _____

Section II - Family History of Indicated Disease

☐ Unknown family history

☐ No known family history

☐ Possible family history

Documented family history

☐ Clinical Diagnosis ONLY

☐ Molecular Diagnosis *(provide a copy of the familial variant report and complete information in Section V)*

Is RUSH testing needed? ☐ Yes *(provide details below)*

☐ Results will alter the **immediate** management and/or treatment of this patient *(specify)*:_____

☐ Results will impact an ongoing pregnancy *(provide EDD, and procedure date if applicable)*:_____

If RUSH testing is required, please provide a target date *(yyyy-Mon-dd) (required)*: _____

Note: TAT is a minimum of 4 weeks.

Section III - Patient Clinical Information

Sex at birth ☐ Female ☐ Male ☐ Unknown

Has this patient received a blood product in the preceding three months?
☐ Yes indicate blood product: _____

Has the patient had a bone marrow transplant? ☐ Yes **(Blood is an incompatible specimen type.)**

Please provide any relevant information regarding your patient's clinical presentation

Section IV - Pedigree *(Provide any relevant family history details, with family member names, ages, and diagnoses included as applicable. If more space is required, attach a separate sheet.)*

Patient Ethnicity / Ancestry: _____

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Section V - Specific Variant Testing

Complete this section only if you are requesting testing for a variant previously identified in the family.
Specific variant testing is available for all genes available on the panels listed below.

- ☐ Cardiac Gene Panel, Specific Variant
- ☐ Connective Tissue Disorder Panel, Specific Variant
- ☐ Inherited Vascular Disorder Panel, Specific Variant

Gene	Mutation / Variant

What is the phenotype / presentation in the proband? _____

Other family members previously tested in MGL ☐ No ☐ Yes ▼

INDEX patient name	MGL Reference Number

Which laboratory performed the proband testing? ☐ Calgary ☐ Edmonton ☐ Other *(specify)* _____

Testing a positive control is recommended if the proband testing was performed at another lab.
A clear copy of the test report on a family member is required if the testing was performed at another laboratory

Section VI – Cardiac, Connective Tissue, and Vascular Gene Panel Requests

Inherited Arrhythmia Panels
- ☐ Brugada Syndrome
- ☐ Catecholaminergic Polymorphic Ventricular Tachycardia Panel
- ☐ Long QT Syndrome Panel
- ☐ Pan Arrhythmia Panel

Cardiomyopathy Gene Panels
- ☐ Arrhythmogenic Right Ventricular Dysplasia / Cardiomyopathy Panel
- ☐ Dilated Cardiomyopathy Panel
- ☐ Hypertrophic Cardiomyopathy Panel
- ☐ Pan Cardiomyopathy Panel

Other Cardiac Gene Panels
- ☐ Comprehensive Cardiac Panel
- ☐ Familial or Inherited Hypercholesterolemia Panel
  Specify untreated LDL-cholesterol level _____ (mmol/L)
- ☐ Inherited Lipid Disorders Panel

Connective Tissue Disorder Panels
- ☐ Aortopathy Panel, Core
- ☐ Aortopathy Panel, Extended
- ☐ Ehlers Danlos Syndrome Panel
- ☐ Loeys-Dietz Syndrome Panel
- ☐ Osteogenesis Imperfecta Panel
- ☐ Stickler Syndrome Panel

Inherited Vascular Disorder Panels
- ☐ Cerebral Cavernous Malformation Panel
- ☐ Hereditary Hemorrhagic Telangiectasia / Arteriovenous Malformation Panel
- ☐ Heritable Heritable Pulmonary Arterial Hypertension Panel
- ☐ Leukodystrophy and/or Porencephaly with Vascular Stroke Panel

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Section VII - Single Gene Test Request

Complete **only** if a panel is not appropriate for the patient.

☐ Cardiac Custom Gene Panel
☐ Cardiac Gene Panel, Single Gene Analysis
☐ Connective Tissue Disorder Panel, Single Gene
☐ Inherited Vascular Disorder Panel, Single Gene

Requesting test for _____ *(indicate the gene)* **and** the presenting phenotype: _____

Requesting test for _____ *(indicate the gene)* **and** the presenting phenotype: _____

Section VIII - Variant Reinterpretation

Complete this section only if you are requesting reinterpretation of a variant previously identified in the family

Gene	Mutation / Variant
What is the clinical phenotype / presentation in the family?	

A clear copy of the test report is required if the testing was performed at another laboratory

Section IX - Additional Comments