

Molecular Genetics LaboratoryBC Children's Hospital & BC Women's Hospital
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• 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	SAMPLE TYPE	
<input type="checkbox"/> STAT (affects pregnancy management) EDD: _____ DD/MM/YY	<input type="checkbox"/> BLOOD	MEDICAL GENETICS ONLY: CVS OR AMNIOCENTESIS: <input type="checkbox"/> DNA <input type="checkbox"/> Cultured <input type="checkbox"/> Uncultured* *consultation required
<input type="checkbox"/> ROUTINE	<input type="checkbox"/> TISSUE ; Surgical Path #: _____ <input type="checkbox"/> DNA* ; MGL Sample ID: _____ *prior approval required, as per policy Quantity: _____ ug OR _____ ug/ul & _____ ul	

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/MM/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"/> Provincial Laboratory Medicine Services Agreement and Consent for Out of Province testing form	SHIPMENT
<input type="checkbox"/> Referral Lab paperwork	
<input type="checkbox"/> Provide Funding Details:	
LABEL	

CM_PW ☐**CONFIDENTIALITY NOTICE**

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