



Lab Use Only. Do not fill out.

Date received: Y _____ M _____ D _____
Specimen type: _____
Condition: _____
Lab #: _____ Tech: _____

Form 1b: Retinoblastoma Genetic Test Requisition

Ordering Options

- Bilateral Retinoblastoma Proband**
Date diagnosed: Y _____ M _____ D _____
- Unilateral Retinoblastoma Proband**
Date diagnosed: Y _____ M _____ D _____
- Known RB1 Familial Variant**
(**must** provide the familial genetic report)
- Affected** **Unaffected**
- Prenatal diagnosis for known RB1 Familial Variant**
(**must** provide familial variant report and maternal sample for MCC)

Patient

Legal last name: _____
 Legal first name: _____
 Preferred first name (if applicable): _____
 Date of birth: Y _____ M _____ D _____
 Sex at birth: **Male** **Female** **Other** specify: _____
 Gender identity: **Same as sex at birth**
 Different than sex at birth specify: _____
 Address: _____
 City: _____ Prov/State: _____
 Postal/Zip code: _____ Country: _____
 Phone: _____

Specimen Information

Refer to *Accepted Samples Reference Sheet*.

Germline sample (**required**):

- Blood sample for DNA** (EDTA or ACD tube)
- DNA from blood**
- Buccal swab** (only for select cases please contact lab prior to submitting)
- Other** (refer to *Accepted Germline Samples Reference Sheet*): _____

Date collected: Y _____ M _____ D _____

Tumour sample:

Note: **not** able to accept FFPE tumour samples

- Fresh RB tumour** **Frozen RB tumour**
- Tumour to follow** **No tumour to follow**
- DNA from tumour***

Date collected: Y _____ M _____ D _____

Prenatal sample:

- Cord Blood** **Chorionic Villus (CVS)**
- Direct Amniotic Fluid** **Cultured Amniocytes**
- Extracted DNA***, Source: _____

Date collected: Y _____ M _____ D _____

* **Must** provide extraction method, **must be performed** by a CLIA-accredited laboratory

Pedigree

If unable to draw the family history please write in below how your patient is related to the other family member(s) who have retinoblastoma.

Referring Specialist

Name: _____
 Specialty: _____
 Contact: _____
 Phone: _____ Fax: _____
 Email: _____
 Signature: _____
 Institution: _____
 Address: _____
 City: _____ Prov/State: _____
 Postal/Zip code: _____ Country: _____
 Additional copies to: _____
 Email: _____
 Fax: _____

Billing

Institution
 Provide details: _____

Patient pay
 Complete **Form 1d: Credit Card Authorization**
 for Non-Covered Services

Ordering Specialist: By submitting this form, I confirm that this test is being ordered for the purpose of prognosis as per the **Laboratory and Specimen Collection Centre Licensing Act** (Ontario, Canada).

impact genetics

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Please ensure to use secure email