Hong Kong Cytogenetics and Medical Genetics Centre Limited
香港染色體及遺傳基因診斷評估中心
18/F, Chevalier Commercial Centre, 8 Wang Hoi Road, Kowloon Bay, Kowloon, Hong Kong
香港九龍九龍灣宏開道八號其士商業中心十八樓 PHONE : (852) 2133-8336 | FAX : (852) 3116-0488

SAMPLE DELIVER TO LABORATORY:
Hong Kong Cytogenetics and Medical Genetics Centre
Room 04-06, 11/F, Fook Hong Industrial Building, Kowloon Bay, HK

HKCMGC Patient ID

CYTOGENETICS AND MOLECULAR GENETICS ASSESSMENT REQUISITION FORM

** Fields are mandatory*

PATIENT INFORMATION

Surname*	**Given Name(s)***	**Date of Birth*** DD / MM / YYYY	**Ethnicity*** ☐Chinese ☐Other:_____
Sex* ☐Male ☐Female ☐Other	**HKID/Passport No.***	**Mailing Address**	**HKCMGC LAB USE ONLY**
Clinic/Institution No.	**Phone No.**		☐ Tick if previously tested *Patient Label*

REFERRING INFORMATION (Fill out or affix official stamp)

Referring Physician*	**Clinic/Institution Name***	
Phone No.*	**Fax No.**	**Email**

Specimen received date/ time*:

BILLING INFORMATION

Bill Type
☐ Charge to Institution
(Select Referral by Physician in the Referral Type)
☐ Direct Payment

Referral Type
☐ Referral by Physician
☐ Referral by Staff: _____
☐ Walk-in

SPECIMEN DETAILS

Specimen Type (x no. of tubes)
Blood:
☐ EDTA (× ___) ☐ Sodium Heparin (× ___)
☐ Clotted (× ___) ☐ ACD Solution B (× ___)

Specimen collection date* DD / MM / YYYY

Specimen collection time* HR : MIN

INDICATION AND TEST REQUESTED

Indication for testing * (Attach supportive material such as previous test reports if available)
☐ Health screening ☐ Disease monitoring ☐ Pre-IVF
☐ Carrier screening (family planning) ☐ Diagnostic (confirmatory)
☐ Recurrent miscarriage Specify clinical manifestation: _____
☐ Infertility _____

Additional information or family history (if any):

Reproductive, Obstetrics and Gynecology, Pediatrics

Karyotyping [KT]
☐ Peripheral Blood [01]

Array-CGH/ Microarray [AC]
☐ Peripheral Blood [01]

PCR-based tests [PC]
☐ α/β-Thalassemia Reverse Dot-Blot [PR]
☐ Triplet Repeat Disorders (Fragile X) [PT]
☐ Triplet Repeat Disorders (Spinocerebellar Ataxia) [95]
☐ Paternity Test [PP] ☐ Paternity Test (Legal Use) [PQ]
☐ PCR-MLPA [PM]#: _____
☐ Thrombophilia Mutation Screening [07]
☐ Y Chromosome Microdeletion Test [YM]

Group Test
☐ Integrated Tests for Autism [ASD01]
☐ Infertility & Recurrent Miscarriages Test [FSA01]
☐ Male Infertility Test [MFT01]

Next-generation Sequencing [NG]
☐ Autism, ADHD & Asperger's Disorder Screening [09]

Cardiology

PCR-based tests [PC]
Sequencing any below
☐ 4 sites [96]/ ☐ 3 sites [97]/ ☐ 2 sites [98]/ ☐ 1 site [99]

Lamin A/C Cardiomyopathy related sites
☐ LMNA (R225X) ☐ LMNA (Q354X)
☐ LMNA (T518fs) ☐ Other: _____

Familial Hypercholesterolemia related sites
☐ LDLR (R257W) ☐ APOB (R532W)
☐ PCSK9 (R93C) ☐ CETP (D459G)
☐ LDLRAP1 (K30fs) ☐ Other: _____

Hypertrophic Cardiomyopathy related sites
☐ MYH7 (Specify:_____) ☐ Other:_____

Next-generation Sequencing [NG]
☐ Familial Cardiovascular Disease Panel [06B]
☐ Specific Cardiovascular Disease Screening [06C]
Specify: _____

Oncology

PCR-based tests [PC]
Specific Sequencing of any
☐ 4 sites [96]/ ☐ 3 sites [97]/ ☐ 2 sites [98]/ ☐ 1 site [99]
Specify gene(s) and site(s):

Next-generation Sequencing [NG]
☐ Comprehensive Cancer *(14 cancer types)* [01]
☐ Breast Cancer [02]
☐ Colorectal Cancer [03]
☐ Lung Cancer [04]
☐ Other Specific Cancer [99]: _____

Circulating Tumor Cells [CTC] #
☐ General cancer screening
☐ Specific cancer type screening
Specify cancer type (or marker):

Cancer Biomarker Multiplex Screening [BM]
☐ Liver Cancer Biomarker Multiplex Screening [01]

Other Tests

☐ Senescence-Associated β-galactosidase [ET01]

Special requests (if any):

Genetic Assessment

Next-generation Sequencing [NG]
☐ Comprehensive Cancer *(14 cancer types)* [01]
☐ Breast Cancer [02]
☐ Colorectal Cancer [03]
☐ Lung Cancer [04]
☐ Clinical Full Exome Panel [05]
☐ Familial Cardiovascular Disease Panel [06B]
☐ Specific Cardiovascular Disease Screening [06C]
Specify: _____
☐ Categorized Inherited Disease(s) [07]
Specify: _____
☐ Full Inherited Disease Panel [08]
☐ Autism, ADHD & Asperger's Disorder Screening [09]
☐ Metabolic Diseases Panel [10]
☐ Sensory Diseases Panel [11]
☐ Neurological Diseases Panel [12A]
☐ Parkinson's Disease, Alzheimer's Disease and Dementia Screening [12B]
☐ Endocrine Diseases Panel [13]
☐ Renal Disease Panel [14]
☐ Mitochondrial Diseases Panel [20]
☐ Other Specific Cancer [99]: _____

DNASalute™ Health Assessment

Next-generation Sequencing [NG]
☐ *DNASalute*™ Comprehensive Health Assessment [15]
☐ *DNASalute*™ Weight, Management & Physiogenomics [16]
☐ *DNASalute*™ Nutrition, Diet Impact & Metabolic Profiles [17]
☐ *DNASalute*™ Anti-aging Parameters, Stress Tolerability & Longevity [18]
☐ *DNASalute*™ Any 1-3 categories package [19]
Specify: _____
☐ Osteoporosis Panel [21]
☐ Chronic Oxidative Stress and Inflammation Panel [22]
☐ Anti-aging, Metabolic Profiles and Stress Tolerability Panel [23]

 # please contact the lab for confirmation and arrangement before ordering

REFERRAL PHYSICIAN / LABORATORY SIGNATURE

Policies, including privacy policy or sample requirement of Hong Kong Cytogenetics and Medical Genetics Centre Limited, which are available on www.hkcmgc.com, apply to this requisition.
I hereby confirm the correctness of the above given information and agree with the stated policies.

Physician/ Referral laboratory/ Provider Signature* _____

Date (DD/MM/YYYY)* _____