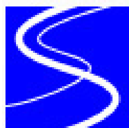

Retinoblastoma Solutions
399 Bathurst Street, Room 13MP-302
Toronto, Ontario M5T 2S8 CANADA

retinoblastomasolutions.org
info@retinoblastomasolutions.org
416-603-5597; 416-603-5622 fax

Retinoblastoma (*RB1*) Genetic Testing Requisition

Patient

Last Name ______________________
First Name ______________________
Date of Birth ______ yyyy / mmm / dd ______
Gender ☐M ☐F

Patient History

☐ Affected
☐ Bilateral ☐ Unifocal ☐ Multifocal
☐ Unilateral ☐ Unifocal ☐ Multifocal
☐ Phenotype Unknown
Diagnosis Date______ yyyy / mmm / dd ______
☐ Unaffected
☐ Fetus/newborn, Delivery Date yyyy / mmm / dd
☐ Sample to test Maternal Cell Contamination

☐ Isolated Case ☐ Positive Family History
Family Previously Tested? ☐ Yes ☐ No
Mutation Identified? ☐ Yes ☐ No
Proband Name ______________________
Mutation ______________________

Relationship to Proband

☐ Proband (first person in a family to be studied)
☐ Parent of Proband
☐ Brother or Sister of Proband
☐ Child of Proband: ☐ Son ☐ Daughter ☐ Prenatal
☐ Other ______________________

Specimen Info

☐ Blood Sample ACD/EDTA(5-10 mls)
☐ DNA from Blood
☐ Fresh Tumor
☐ Frozen Tumor
☐ DNA from Tumor
☐ *Tumor to follow* ☐ ***No** Tumor to follow*

Pre-Natal:
☐ Cord Blood ☐ CVS ☐ Cultured Amniocytes

Date of Collection: yyyy / mmm / dd ______

Time of Collection: HH:MM (use 24h clock)

Referring Specialist

Name ______________________
Specialty ______________________
Contact ______________________
Tel ______________ Fax ______________
e-mail ______________________
Institution ______________________
Address ______________________
____
City ______________ Prov (St) ______________
Postal Code______________Country______________
Additional Copies to: ______________________
e-mail ______________ Fax ______________

Billing Information

☐ Payment enclosed
☐ Bill Institution ☐ Bill Patient
☐ Bill Third Party Insurer
☐ Information and Pre-approval enclosed

Billing Address
Name ______________________
Address 1 ______________________
Address 2 ______________________
Address 3 ______________________

☐ Bill Credit Card
☐ VISA ☐ Mastercard
Cardholder ______________________
Card Num ______________________
Expiration ______ yyyy / mmm / dd ______

Pedigree

SOP ADM-1100
Last update: 29-Nov-10 jm