Lab Use Only

Res Lab #: _____

Date Rec'd: _____

Time Rec'd: _____

Initials: _____

National Inherited Bleeding Disorder Genotyping Laboratory

Department of Pathology and Molecular Medicine
Queen's University, Kingston, Ontario

AHCDC

Hemophilia A and B Genotype Testing Requisition

Patient Name: Doe, John (Surname, First Name) **Sex:** Male ☑ Female ☐

DOB: 2019/01/01 (YY/MM/DD) **Unique Identifier:** 0000-000-000-AB (eg. Health card #, Hospital #) **CBDR #:** n/a

Date of specimen collection: 2026/09/07 (YY/MM/DD) **Phlebotomist:** A. Phlebotomist

Referring Clinic: Canadian Hospital **Report to:** AHCDC member **Fax #:** 123-456-0000

Test Requested: **Hemophilia A** ☑ **Hemophilia B** ☐

Coagulation Factor Level: **Factor VIII** 0.1 U/mL **Factor IX** _____ U/mL

Inhibitor: Yes ☐ No ☑ **Inhibitor Titre:** _____ B.U.

Has intron 22 inversion testing been done? Yes ☐ No ☑

Information Requested:
- ☑ Confirmation of diagnosis
- ☐ Carrier status
- ☐ Prenatal diagnosis

Pregnant? Yes ☐ No ☑

Have samples from this family been sent to this lab before? Yes ☐ No ☑

If Yes, specify n/a

Relationship to this patient n/a

Sample Requirements:

6 cc whole blood

EDTA (lavender top) or

ACD (yellow top) or

DNA

Ship to:

Attn: Gina Jones/Nguyen Nguyen
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