Lab Use Only
Res Lab #: _____
Date 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: 2010 / 01 / 01 (YY / MM / DD) **Unique Identifier:** 0000-000-000-AA (eg. Health card #, Hospital #) **CBDR #:** n/a

Date of specimen collection: 2024 / 08 / 01 (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 ☑ n/a

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/Samira Kheitan
Department of Pathology and Molecular Medicine
Queen's University, Richardson Laboratory, Room 201
88 Stuart St., Kingston, Ontario K7L 3N6
Tel: 613-533-3187 FAX: 343-344-2733
Email: NIBDGL@ queensu.ca