

**MITOCHONDRIAL
LABORATORY**

555 University Avenue
Room 3642, Atrium
Toronto, ON, M5G 1X8, Canada

Tel: 416-813-7200
Fax: 416-813-5431

Patient Last Name: _____

First Name: _____

Date of Birth (DD/MM/YYYY): _____

Gender: Male Female Unknown

For Canada Only

Health Card #: _____

Version: _____

Issuing Province: _____

MITOCHONDRIAL TESTING

Referred-in Requisition

Specimen Collection Information

Date (DD/MM/YYYY)	Time (HH:MM)	Collected by:
_____	_____	_____

Sample #: _____	If fibroblasts, # of passages: _____	Date of Referral (DD/MM/YYYY) _____
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Referring Physician / Institution		
Name	Address	Telephone
_____	_____	_____

Note: DO NOT submit specimens from patients with HIV+ve status. HIV+ve status interferes with testing.

SKIN FIBROBLAST, AMNIO/CVS TESTING

<input type="checkbox"/> Pyruvate Determination for L/P ratio <input type="checkbox"/> Lactate Determination for L/P ratio <input type="checkbox"/> Cytochrome Oxidase (Comp. IV) <input type="checkbox"/> Succinate Cytochrome C Reductase (Comp. II+III)	<input type="checkbox"/> Pyruvate Dehydrogenase - Total <input type="checkbox"/> Pyruvate Decarboxylase - E1 <input type="checkbox"/> Pyruvate Dehydrogenase - E2 <input type="checkbox"/> Pyruvate Dehydrogenase - E3 <input type="checkbox"/> Pyruvate Carboxylase (PC) <input type="checkbox"/> Phosphoenolpyruvate carboxykinase (PEPCK)	<p>For in-patient: Skin biopsy collection medium can be obtained from Tissue Culture Laboratory (ext 202394) or Pathology (ext 205944). The sample MUST be sent to Tissue Culture Laboratory (Rm # 3225).</p> <p>For testing on amniocytes: Provide at least 3 confluent 25 mL flasks of amniocytes with the same number of flasks of at least two different controls. Keep a backup flask growing. For controls use amniocytes/CVS from individuals approximately the same gestation and age, "discards" from testings for LATE MATERNAL AGE.</p> <p>For testing on outpatients: Provide 2 x 25 mL flasks of cell culture. Cells will be cultured by Tissue Culture Laboratory for the duration of the tests.</p> <p>Note: All fibroblast and amnio specimens must be shipped at room temperature. For shipment of skin biopsies call Tissue Culture Laboratory at 416-813-7654 ext 202394.</p>
<input type="checkbox"/> Partial Screen: All of the above tests with the exception of PC, PEPCK <input type="checkbox"/> Total screen: All of the above tests		
<input type="checkbox"/> Skin fibroblast mitochondrial isolation (NADH: cytochrome c reductase (CI+III), CII+III, CIV, ATPase (CV), citrate synthase (CS))		<p>Test requires 20 plates (10 cm) for mitochondrial isolation with the same number of plates from a control cell line, and thus will delay testing and results.</p>

BIOPSY TESTING ON FROZEN TISSUE (Total tissue homogenate: muscle, liver, heart, kidney)

<input type="checkbox"/> Comp I+III, II+III, IV and CS	<p>Provide about 50 mg of tissue in a plastic cryovial snap frozen in liquid nitrogen.</p> <p>Note: Specimen should NOT be immersed in isopentane or any other fluid before freezing. All frozen specimens must be shipped in a cryovial on plenty of dry ice. Ship early in the week by overnight courier. Specimens received thawed CANNOT be tested.</p>
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BIOPSY TESTING ON ENDOCARDIAL BIOPSY

<input type="checkbox"/> Comp I+III, II+III, IV and CS	<p>Make arrangement with the lab at least 24 hrs prior to the procedure. Provide 2-5 mg fresh specimen.</p> <p>Specimen should be transported in a small container ON ICE.</p>
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BIOPSY TESTING ON ISOLATED MUSCLE MITOCHONDRIA, FRESH TISSUE

<input type="checkbox"/> NADH: ubiquinone reductase (CI), CI+III, Succinate DCIP reductase (CII), CII+III, CIV, CV, CS	<p>Make arrangement with the lab at least 24 hrs prior to the biopsy. Provide 250-300 mg of fresh muscle for mitochondrial isolation. Specimen that weighs less than 200 mg will be snap frozen and processed as "frozen tissue"</p> <p>All fresh biopsies should be transported in a plastic container ON ICE.</p>
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Please continue and complete the 'Clinical Information Sheet' on page 2.

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Referring Physician / Institution

Name	Address	Telephone
_____	_____	_____

Please complete and submit this form in conjunction with the "Mitochondrial Testing Requisition".

Clinical information (Please check):

Age at onset: _____

CNS	Ophthalmologic	Muscle	Cardiac	General
<input type="checkbox"/> Microcephaly <input type="checkbox"/> Developmental Delay <input type="checkbox"/> Stroke-like episodes <input type="checkbox"/> Ataxia <input type="checkbox"/> Myoclonus <input type="checkbox"/> Dystonia <input type="checkbox"/> Sensorineural hearing loss <input type="checkbox"/> Seizures <input type="checkbox"/> Encephalopathy <input type="checkbox"/> Ophthalmoplegia <input type="checkbox"/> Leigh's Disease <input type="checkbox"/> Basal Ganglia Calcification	<input type="checkbox"/> Optic atrophy <input type="checkbox"/> Leber's HON <input type="checkbox"/> Pigmentary retinopathy <input type="checkbox"/> Cortical Blindness <input type="checkbox"/> Nystagmus Nerve <input type="checkbox"/> Neuropathy <input type="checkbox"/> Axonal <input type="checkbox"/> Demyelinating Hepatic <input type="checkbox"/> Hepatic dysfunction <input type="checkbox"/> Hepatomegaly Renal <input type="checkbox"/> Renal tubular acidosis	<input type="checkbox"/> Myopathy <input type="checkbox"/> Hypotonia <input type="checkbox"/> Exercise intolerance <input type="checkbox"/> Ptosis	<input type="checkbox"/> Conduction abnormalities <input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Hypertrophic <input type="checkbox"/> Dilatative <input type="checkbox"/> Other	<input type="checkbox"/> Failure to thrive <input type="checkbox"/> Feeding problems <input type="checkbox"/> Lethargy <input type="checkbox"/> Dysmorphic facies
		Relevant family history		
<div style="border: 1px solid black; height: 100px;"></div>				

LABORATORY DATA (IF KNOWN):

<input type="checkbox"/> Serum lactate: _____	<input type="checkbox"/> CSF Lactate: _____	<input type="checkbox"/> EMG: _____	<input type="checkbox"/> ABR: _____
<input type="checkbox"/> ALT: _____	<input type="checkbox"/> AST: _____	<input type="checkbox"/> NCS: _____	<input type="checkbox"/> VEP: _____
<input type="checkbox"/> Alkaline phosphatase: _____	<input type="checkbox"/> BUN: _____	<input type="checkbox"/> CT: _____	<input type="checkbox"/> SSEP: _____
<input type="checkbox"/> Creatinine: _____	<input type="checkbox"/> Other: _____	<input type="checkbox"/> MRI: _____	

Past muscle or skin biopsy Yes No

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BILLING FORM

How to complete the Billing Form: (Completion of Billing Form NOT required for patients with an Ontario Health Card Number.)

- Referring Physician completes the appropriate section below to specify billing method.
- Send requisition and completed "Billing Form" with specimen.
- Invoices are sent upon completion of each test/service.

Option 1: Complete to have the Healthcare Provider billed:

Your Referring Laboratory's Reference #: _____
 Billing address of hospital, referring laboratory:
 Name: _____
 Address: _____
 City: _____ Prov/State: _____
 Postal/Zip Code: _____ Country: _____
 Contact Name: _____
 Contact Telephone #: _____

Option 2: Interim Federal Health Program (IFHP)

Submit a copy of the Interim Federal Health Certificate (Refugee Protection Claimant Document) with the photo and UCI# visible for coverage to be confirmed.
 UCI# _____
 ICD code (lab use only): _____

Option 3: Complete to have Patient/Guardian billed directly:

If you elect to have patient/guardian billed:

- Patient/Guardian billing information below must be complete; otherwise, the healthcare provider will be billed.
- Please advise the patient/guardian to expect a bill from our laboratory.
- Provide us with patient's valid credit card information.
- Unfortunately, we cannot accept personal checks.
- **In this case, the patient/guardian is solely responsible for the charges.**

Relation to patient (check one): Patient Guardian/Parent

Method of Payment (check one): American Express MasterCard Visa

Name as it appears on credit card: _____

Credit card #: _____

Expiry date on credit card: _____

CVS#- found on back of card (Required): _____

Mailing Address of Patient/Guardian (if different from requisition):

Name: _____
 Address: _____
 _____ Apt. #: _____
 City: _____ Prov/State: _____
 Postal/Zip Code: _____ Country: _____

Additional Contact Information

Patient's phone # with area code: _____

 - or -
 Guardian's phone # with area code: _____
