DNA SEQUENCING REQUEST FORM

Clinical Genomics Centre
Mount Sinai Hospital
600 University Avenue, 6th Floor, Room 6-423
Toronto, Ontario M5G 1X5, Canada

http://www.clinicalgenomics.ca
Tel: 416-586-4800 ext. 5618

Date:_____
User's Name: _____
Principal Investigator: _____
Department: _____
Institute: _____
Tel: _____ Fax:_____
E-mail: _____

Billing Address:
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PAYMENT INFORMATION: Visa/Master Card/AMEX Number: _____
Purchase order Nr**:** _____ Expiry (MM/YY): _____
Card Holders Name: _____

Template Requirement:

Plasmid DNA: 10 µl at 0.2-0.6 µg/µl purified plasmid DNA per reaction. DNA should be eluted in H2O or 0.1x elution buffer.

PCR fragment: 10 µl at 10-50 ng/µl of purified product per reaction. DNA should be eluted in H2O or 0.1x elution buffer.

Has your DNA sample been checked on an agarose gel? ☐Yes. ☐No. Gel picture attached
Method for DNA purification: _____

COMMON PRIMER(S):

☐T3 ☐T7 ☐T7-term ☐M13-For ☐M13-Rev ☐pGEX5' ☐pGEX3' ☐EGFP-C ☐EGFP-N
☐DsRed1-C ☐DsRed1-N ☐V5-Rev ☐T7 ☐SP6 ☐V5-Rev ☐DsRed1-N Express-For

Customer Primers: Please adjust the concentration to **2 pmol/µl**.

TYPE OF SERVICE:

☐Cloning Verification ☐Sequencing unknown sequences ☐Mutation and SNP discovery/identification
* Additional $ 2 for sequence editing if required: ☐

METHOD FOR RECEIVING RESULTS:

☐E-Mail Chromatogram file, ☐E-Mail Text and Chromatogram file, ☐Pickup printout Chromatogram file

	Sample name	Conc. (µg/µl)	DNA type (plasmid/PCR	Size (bp)	Primers	Remarks
1						
2						
3						
4						
5						

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	Sample name	Conc. µg/µl	DNA type (plasmid/PCR	Size (bp)	Primers	Remarks
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