

## 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: \_\_\_\_\_

Billing Address: \_\_\_\_\_

User's Name: \_\_\_\_\_

Principal Investigator: \_\_\_\_\_

Department: \_\_\_\_\_

Institute: \_\_\_\_\_

Tel: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

**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 H<sub>2</sub>O or 0.1x elution buffer.

PCR fragment: 10 µl at 10-50 ng/µl of purified product per reaction. DNA should be eluted in H<sub>2</sub>O 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. $\mu\text{g}/\mu\text{l}$	DNA type (plasmid/PCR)	Size (bp)	Primers	Remarks
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7						
8						
9						
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