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SickKids®
THE HOSPITAL FOR SICK CHILDREN
Paediatric Laboratory Medicine

555 University Avenue
Room 3416, Roy C. Hill Wing
Toronto, ON, M5G 1X8, Canada

Tel: 416-813-7200 x1
Fax: 416-813-7732

(CLIA # 99D1014032)

Patient Name:
Date of Birth (DD/MM/YYYY):
Gender: ☐ Male ☐ Female MRN:
Parent's Names:
Address:

Telephone #:
For Canada Only
Provincial Health Card #: Version:
Issuing Province:

Genome Diagnostics – Cancer Testing

www.sickkids.ca/genome-diagnostics

Referring Physician:

Name: _____
Institution: _____
Address: _____
_____
Phone: _____ Fax: _____
Email address: _____
Signature *(required)*: _____

Copy Report To:

Name: _____
Address: _____
Phone: _____ Fax: _____

Sample Information:

Date obtained (DD/MM/YYYY): ____/____/____
Your referring laboratory reference #:
☐ Blood in EDTA (purple top tube): min. 4 mL
☐ DNA: min. 200 ug in low TE buffer (Source: _____)
☐ Tissue (Source: _____)
☐ Other (Specify: _____)
Pathology Specimen ID: _____
Tumour Cellularity (%): _____
Closed consent:
☐ If checked, all remaining DNA will be discarded upon notification by the ordering physician that all DNA testing has been completed

Responsible Pathologist:

Name: _____
Address: _____
Your referring laboratory reference #: _____
Phone: _____ Fax: _____

Laboratory Use

Date (DD/MM/YYYY) | **Time Received: Germline**
____/____/____ _____ h
Date (DD/MM/YYYY) | **Time Received: Tumour**
____/____/____ _____ h
Lab ID (Germline/Tumour): _____
Specimen type, amt & # of tubes: _____
Germline: _____
Tumour: _____
Patient ID: _____

Test request/ICD-O code *(write below and/or check box(es) on pages 2):*

_____

Reason for Testing:

☐ Tumour and Germline Testing
☐ Germline testing only
☐ Familial mutation/variant analysis
☐ Follow up testing (disease progression, relapse)
☐ Bank DNA only
☐ Other (Specify): _____

If expedited testing is requested, please indicate reason

☐ Treatment/management: _____
☐ Other (Specify: _____)

Familial Mutation/Variant Analysis:

For prenatal testing and cases where a familial mutation or variant is known, please complete below and attach a copy of the proband's report:

Gene/ Transcript: _____
Mutation/variant(s) (c., p. and/or g.) _____
SickKids order number: _____
SickKids family number: _____
Name of proband: _____
Relationship to proband: _____

Clinical Diagnostics and Family History:

Ethnicity of patient: _____
Known family history? ☐ Yes ☐ No ☐ Unknown
Age at diagnosis: _____
Please draw or attach a pedigree and provide any relevant information below, including clinical and family history details, as this is important for accurate interpretation of results. Refer to Page 3 for additional space.

Ordering Checklist:

☐ Specimen tube labeled with at least two identifiers
☐ Completed test requisition form *(pages 1-4)*
Clinical information must be provided on pages 2 -3 for all Next-Generation Sequencing tests. Testing will not proceed until these are provided.
☐ Completed billing form *(page 4, if applicable)*

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LIST OF CANCER TESTING AVAILABLE
For current list of genes please visit: http://www.sickkids.ca/genome-diagnostics

Select tumour type:

Solid tumour

Select tumour type:

- ☐ Colon adenocarcinoma - C18-C20-8140/3
- ☐ Desmoid tumour - 8821/1
- ☐ Ewing Sarcoma - 9260/3
- ☐ Malignant peripheral nerve sheath tumour - 9540/3
- ☐ Medullary carcinoma - 8510/3
- ☐ Nephroblastoma (Wilms tumour) - 8960/3
- ☐ Neuroblastoma - 9500/3
- ☐ Osteosarcoma - 9180/3
- ☐ Papillary carcinoma - 8050/3
- ☐ Rhabdomyosarcoma (NOS-8900/3, Embryonal-8910/3 or Alveolar-8920/3)
- ☐ Synovial sarcoma - 9040/3
- ☐ Other; Specify ICD-O code*: (_____)

CNS tumour

Select tumour type:

- ☐ Astrocytoma - 9400/3
- ☐ Ependymoma - 9391/3
- ☐ Glioblastoma - 9440/3
- ☐ Medulloblastoma - 9470/3
- ☐ Primitive neuroectodermal tumour - 9473/3
- ☐ Other; Specify ICD-O code*: (_____)

Hematological malignancy

Select tumour type:

- ☐ Acute lymphoblastic leukemia - 9826/3
- ☐ B-cell lymphoblastic leukemia/lymphoma - 9811/3
- ☐ T-cell lymphoblastic leukemia/lymphoma - 9837/3
- ☐ Acute Myeloid Leukemia
- ☐ Chronic Myeloid Leukemia - 9863/3
- ☐ Hodgkin Lymphoma - 9650/3
- ☐ Non-Hodgkin Lymphoma - 9591/3
- ☐ Mediastinal large cell lymphoma - 9679/3
- ☐ Other; Specify ICD-O code*: (_____)

*** ICD-O codes available at: http://codes.iarc.fr**

Select test type:

Tumour and Germline testing:

Comprehensive testing includes clinically actionable genes with strong evidence for association with cancer and predisposition to cancer.

- ☐ **Comprehensive Cancer Panel analysis (864 genes)**

Germline only testing:

Comprehensive Cancer Predisposition testing includes clinically actionable genes with strong evidence for association with cancer predisposition.

- ☐ **Comprehensive Cancer Predisposition analysis (864 genes)**

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Genome Diagnostics – Cancer Testing

ADDITIONAL RELEVANT CLINICAL INFORMATIONs

FAMILY HISTORY

Please draw or attach a pedigree and provide any relevant information below, including clinical and family history details, as this is important for accurate interpretation of results.

Previous Genetic Testing:

☐ No

☐ Yes; Specify Test Results:

OTHER CLINICAL OR PATHOLOGICAL INFORMATION:

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Genome Diagnostics – Cancer Testing

Completion of Billing Form NOT required for patients with an Ontario Health Card Number.

BILLING FORM

At your direction, we will bill the hospital, referring laboratory, referring physician, or a patient/guardian, for the services we render

- Invoices are sent upon completion of each test/service.
- Invoices are itemized and include the date of service, patient name, CPT code, test name and charge.
- Contact SickKids' Genome Diagnostics Laboratory at 416-813-7200 x1 with billing inquiries.

How to complete the Billing Form:

- **Referring Physician completes the appropriate section below to specify billing method.**
- **Send requisition and completed "Billing Form" with specimen.**

Section 1: Complete to have the Healthcare Provider billed:

Your Referring Laboratory's Reference #: _____

Billing address of hospital, referring laboratory, clinic, referring physician, or medical group: (if different from requisition):

Name: _____

Address: _____

City: _____ Prov/State: _____

Postal/Zip Code: _____ Country: _____

Contact Name: _____ Contact Telephone #: _____

Section 2: 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.***

Send bill to (check one): ☐ Patient ☐ Guardian

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

Name as it appears on credit card: _____

Credit card # : _____

Expiry date on credit card: _____

Signature of credit card holder (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:

_____