



**THE HOSPITAL FOR
SICK CHILDREN**

**Paediatric
Laboratory Medicine**

PATHOLOGY LABORATORY

555 University Avenue
Room 3110, Burton Wing
Toronto, ON, M5G 1X8, Canada

Tel: 416-813-5967
Fax: 416-813-5974

Patient Name: _____

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

Gender: Male Female

Parent's Name: _____

Address: _____

For Canada Only

Health Card #: _____

Issuing Province _____

Version: _____

MOLECULAR PATHOLOGY

Referred-in Requisition

Referring Physician

| | |
|--|--|
| Name: _____ Institution: _____ Referring Laboratory: _____ Referring Lab Accession #: _____ Telephone Number: _____ Fax Number: _____ | Mailing Address: _____ |
|--|--|

Copy Report To

| | |
|---|------------------------------------|
| Name: _____ Telephone Number: _____ Fax Number: _____ | Mailing Address: _____ |
|---|------------------------------------|

General Test Information

| | |
|--------------------------|---|
| <input type="checkbox"/> | Single test requested. |
| <input type="checkbox"/> | Multiple tests requested. <input type="checkbox"/> Perform <u>all</u> requested tests. <input type="checkbox"/> If the requested targeted test(s) is negative, run the selected NGS panel |

Specimen Information

Tumor type: _____
 Suspected alteration(s): _____

Link Test Catalogue

- <http://www.sickkids.ca/paediatriclabmedicinems/test-catalogue/molecular-pathology-listing.html>

Reasons for Referral (optional)

Special Requests

- Please contact us at nanostring.lab@sickkids.ca

For Laboratory Use

Date received (DD/MM/YYYY): _____ Pathology #: _____
 Technologist: _____ Tissue received on dry ice (if applicable) Yes No

MOLECULAR PATHOLOGY

Referred-in Requisition

NanoString Test List

| | | |
|---|--------------------------------------|--|
| <p>NOTE: Please consult the Paediatric Laboratory Medicine Webpage (http://www.sickkids.ca/paediatriclabmedicinems/test-catalogue/molecular-pathology-listing.html) for detailed information about the transcripts, fusions, and duplications targeted by the panels.</p> | <p>Specimen Type and Information</p> | <p><input type="checkbox"/> Frozen tissue: ~40mg <input type="checkbox"/> FFPE scrolls: 10 x 10µm sections <input type="checkbox"/> FFPE block</p> |
| <p>PROVIDE ONE SPECIMEN PER TEST</p> | | |

| | |
|--------------------------|--|
| <input type="checkbox"/> | <p>MEDULLOBLASTOMA SUBTYPING</p> <ul style="list-style-type: none"> The tissue provided must have been confirmed as a medulloblastoma by a pathologist The tissue provided must be representative of the tumour One H&E stained slide representative of the tested tissue must be provided RNA-based assay |
|--------------------------|--|

| | |
|--------------------------|---|
| <input type="checkbox"/> | <p>SARCOMA FUSION TRANSCRIPT PANEL</p> <ul style="list-style-type: none"> The tissue provided must be representative of the tumour One H&E stained slide representative of the tested tissue should be provided RNA-based assay |
|--------------------------|---|

| | |
|--------------------------|--|
| <input type="checkbox"/> | <p>LOW GRADE GLIOMA FUSION TRANSCRIPT & DUPLICATION PANEL 1</p> <ul style="list-style-type: none"> The tissue provided must be representative of the tumour One H&E stained slide representative of the tested tissue should be provided RNA-based assay |
|--------------------------|--|

| | |
|--------------------------|---|
| <input type="checkbox"/> | <p>PAEDIATRIC GLIOMA FUSION TRANSCRIPT & DUPLICATION PANEL 2</p> <ul style="list-style-type: none"> The tissue provided must be representative of the tumour One H&E stained slide representative of the tested tissue should be provided RNA based assay |
|--------------------------|---|

| | |
|--------------------------|--|
| <input type="checkbox"/> | <p>EPENDYMOMA FUSION TRANSCRIPT PANEL</p> <ul style="list-style-type: none"> The tissue provided must be representative of the tumour One H&E stained slide representative of the tested tissue should be provided RNA based assay |
|--------------------------|--|

MOLECULAR PATHOLOGY

Referred-in Requisition

DNA Microarray Test List - Pathology/Cytogenetics

| | | | |
|---|--|--------------------------------------|-------------------------------|
| <ul style="list-style-type: none"> The tissue provided must be representative of the tumour | | PROVIDE ONE SPECIMEN PER TEST | Specimen Type and Information |
| <input type="checkbox"/> <p>SNP FFPE DNA SNP microarray - OncoScan - FFPE</p> <ul style="list-style-type: none"> The Affymetrix OncoScan CNV Assay is a whole genome copy number microarray-based assay that enables the detection of copy number variation /loss of heterozygosity (LOH) Number of markers: over 220,000 SNPs DNA-based assay <i>Note: The assay has the same copy number coverage as the OncoScan CNV Plus assay but does not include somatic mutation coverage</i> <p style="background-color: blue; color: white; padding: 2px;">Reasons for Referral</p> | <input type="checkbox"/> FFPE block <input type="checkbox"/> FFPE scrolls: 10 x 10µm sections | | |
| <input type="checkbox"/> <p>SNP FRESH SNP microarray - CytoScan - FRESH</p> <ul style="list-style-type: none"> The Affymetrix CytoScan HD Assay is a whole-genome copy number microarray-based assay that enables the detection of copy number variation / loss of heterozygosity (LOH) Number of non-polymorphic markers: 1,953,246 Number of SNP markers: 743,304 DNA-based assay <p style="background-color: blue; color: white; padding: 2px;">Reasons for Referral</p> | <input type="checkbox"/> Frozen tissue: ~40mg | | |

Next Generation Sequencing Test List - Pathology

| | | | |
|--|---|--------------------------------------|--|
| <ul style="list-style-type: none"> The tissue provided must be representative of the tumour The One H&E stained slide representative of the tested tissue should be provided | | PROVIDE ONE SPECIMEN PER TEST | <input type="checkbox"/> Frozen tissue: ~40mg <input type="checkbox"/> FFPE scrolls: 10 x 10µm sections <input type="checkbox"/> FFPE block |
| <input type="checkbox"/> <p>Illumina TruSight RNA Pan-Cancer Panel</p> <ul style="list-style-type: none"> Panel: 1385 oncology genes. Please consult the DPLM Catalogue Test webpage for complete gene list RNA-based assay | Reasons for Referral - MANDATORY | | |



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Parent's Name:

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MOLECULAR PATHOLOGY

Referred-in Requisition

Shipping Instructions

All specimens that DO NOT MEET the transport requirements will be REJECTED.

1. Specimen can be send via Taxi, Courier or Regular Post to the following address:

The Hospital for Sick Children
Division of Pathology
Room 3102, Burton
555 University Ave.
Toronto, ON, Canada, M5G 1X8

2. To avoid compromising specimen integrity, **ship Monday through Wednesday only.**

Do not ship specimen on the day of or the day before a Canadian statutory holiday.
Canadian Holidays to consider:

- New Year's Day – January 1
- Good Friday – the Friday before Easter
- Victoria Day – Monday on or before May 24
- Canada Day – July 1
- Civic Holiday – First Monday in August
- Labour Day – First Monday in September
- Thanksgiving – Second Monday in October
- Christmas Day – December 25
- Boxing Day – December 26

3. SNAP FROZEN TISSUES.

- All frozen tissues must be shipped on dry ice.
- Specimen must be sent Monday through Wednesday only.
- Never place samples directly on the dry ice.
- We recommend a minimum of 4 kg (approx. 10 lbs.) of dry ice for international shipments.
- Do not over-pack. Over-packed Styrofoam will crack and dry ice will be consumed faster.
- Regulations require that the diamond shaped dry ice sticker be placed on the outside of the shipping box.

4. PARAFFIN SCROLLS.

- Scrolls from FFPE tissues can be shipped at room temperature.
- Scrolls must be shipped immediately after shaving.

5. PARAFFIN BLOCKS.

- Block(s) from FFPE tissues can be shipped at room temperature.

6. To avoid shipping problems:

- To schedule a shipment, contact a freight forwarder who knows how to export medical specimens from your country.
- Ask the forwarder to help you with local regulations, completing the necessary documentation and arranging to clear the shipment through Canada Customs.
- Transit times may be more than one day. Please take this into account when packaging your samples.

Patient Name: _____

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

Gender: Male Female

MRN: _____

MOLECULAR PATHOLOGY

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, or a patient/guardian, for the services we render

- Invoices are sent upon completion of each test/service.
- Contact SickKids' Pathology Laboratory at 416-813-5967 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:

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/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: _____