



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
Date (DD/MM/YYYY) | Time Received: Tumour
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)

Patient Name:

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Gender: Male Female

MRN:

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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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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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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: _____

City: _____ Prov/State: _____ Apt. #: _____

Postal/Zip Code: _____ Country: _____

Additional Contact Information

Patient's phone # with area code: _____

- or -

Guardian's phone # with area code: _____