THE HOSPITAL FOR SICK CHILDREN

Paediatric Laboratory Medicine

MOLECULAR PATHOLOGY LABORATORY

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

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

CLINICAL MOLECULAR DIAGNOSTICS

Patient Name:

Date of Birth (DD/MM/YYYY):

Gender: ☐ *Male* ☐ *Female*

Parent's Name:

Address:

For Canada Only

Health Card #: *Version:*

Issuing Province

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

☐	Single test requested.
☐	Multiple tests requested. ☐ Perform all requested tests. ☐ If the requested targeted test(s) is negative, run the selected NGS panel

Specimen Information

Tumor type: ______________________

Suspected alteration(s): ______________________

Link Test Catalogue

- https://www.sickkids.ca/en/care-services/for-health-care-providers/lab-tests/lab-test-catalogue/

Reasons for Referral (optional)

Special Requests

- Please contact us at cmd.laboratory@sickkids.ca

For Laboratory Use

Date received (DD/MM/YYYY): ______________________

Pathology #: ______________________

Technologist: ______________________

Tissue received on dry ice *(if applicable)* ☐ Yes ☐ No

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NanoString Test List

NOTE: Please consult the Paediatric Laboratory Medicine Webpage (https://www.sickkids.ca/en/care-services/for-health-care-providers/lab-tests/lab-test-catalogue/) for detailed information about the transcripts, fusions, and duplications targeted by the panels.	Specimen Type and Information **PROVIDE ONE SPECIMEN PER TEST**	☐ Frozen tissue: ~40mg ☐ FFPE scrolls: 10 x 10µm sections ☐ FFPE block

☐ **MEDULLOBLASTOMA SUBTYPING**
- 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
- Medulloblastoma Subtyping Panel gene list

☐ **SARCOMA FUSION TRANSCRIPT PANEL**
- 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
- Sarcoma Fusion Transcript Panel gene list

☐ **LOW GRADE GLIOMA FUSION TRANSCRIPT & DUPLICATION PANEL 1**
- 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
- Low Grade Glioma Fusion gene list

☐ **ATYPICAL TERATOID RHABDOID TUMOUR (ATRT)**
- The tissue provided must have been confirmed as a ATRT by a pathologist
- 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
- Atypical Teratoid Rhabdoid Tumour gene list

☐ **EPENDYMOMA FUSION TRANSCRIPT PANEL**
- 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
- Ependymona Fusion Transcript Panel gene list

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DNA Microarray Test List - Pathology/Cytogenetics

		PROVIDE ONE SPECIMEN PER TEST	Specimen Type and Information
	• The tissue provided must be representative of the tumour		
☐	**SNP FFPE DNA** **SNP microarray - OncoScan - FFPE** • The Affymetrix OncoScan CNV Assay is a whole genome copy number micro-array-based assay that enables the detection of copy number variation /loss of heterozygosity (LOH) • Number of markers: over 220,000 SNPs • DNA-based assay • *Note: The assay has the same copy number coverage as the OncoScan CNV Plus assay but does not include somatic mutation coverage* **Reasons for Referral**		☐ FFPE block ☐ FFPE scrolls: 10 x 10μm sections
☐	**SNP FRESH** **SNP microarray - CytoScan - FRESH** • The Affymetrix CytoScan HD Assay is a whole-genome copy number microarray-based assay that enables the detection of copy number variation / loss of hetero-zygosity (LOH) • Number of non-polymorphic markers: 1,953,246 • Number of SNP markers: 743,304 • DNA-based assay **Reasons for Referral**		☐ Frozen tissue: ~40mg

Next Generation Sequencing Test List - Pathology

		PROVIDE ONE SPECIMEN PER TEST	
	• The tissue provided must be representative of the tumour • One H&E stained slide representative of the tested tissue **must** be provided		☐ Frozen tissue: ~40mg ☐ FFPE scrolls: 10 x 10μm sections ☐ FFPE block
☐	**Illumina TruSight RNA Pan-Cancer Panel** • Panel: 1385 oncology genes. Please consult the DPLM Catalogue Test webpage for complete gene list or click here. • RNA-based assay • TruSight RNA Pan-Cancer Target Genes		**Reasons for Referral - MANDATORY**

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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.

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BILLING FORM

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

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 416-813-5974 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: ______________________________

CVV#- 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:
____