# Molecular Diagnostic Laboratory – Hereditary Cancer Test Requisition

Deliver all specimens to:
Health Sciences Centre-Central Services
MS551-820 Sherbrook Street
Winnipeg, Manitoba R3A 1R9

For specimen requirements and test information contact:
MDL Telephone: 204-787-1024
Lab Fax: 204-787-3846
Call Centre (24 hr): 204-787-1534

Additional requisitions and sample requirements at:
www.sharedhealthmb.ca/ For Health Providers/ Diagnostic Services/ Lab Information Manual

**SHIP SAMPLES AT ROOM TEMPERATURE**

Acceptance Policy 10-50-03: Requirements for Test Requisitions 2.1 - Fields marked with * are mandatory and must be clearly legible or can result in specimen rejection.

| **Ordering Provider Information** | | Patient Information |
|---|---|---|
| *Last & Full First Name: | Billing Code: | *Last, First Name: (per Health Card) |
| *Ordering Facility: | | * Date of Birth (dd/mm/yyyy) |
| Address: | | *Biological Sex: Female Male |
| Critical Results Phone Number: | Fax No: | *PHIN:<br>Specify if other province/ DND)<br>MRN: |
| Phone No.: | | |
| **Copy Report To:** *(if info missing, report may not be sent)* | | Encounter Number: |
| Last & Full First Name: | Fax No: | Patient Phone No: |
| Facility Name/ Address: | Phone No.: | Patient Address: |
| Last & Full First Name: | Fax No: | Demographics verified:<br>❑ Health Card ❑ Armband ❑eChart/CR ❑ Other |
| Facility Name/ Address: | Phone No.: | |

| **Collection Information** *(fields marked with ♦ required by person collecting sample)* | | |
|---|---|---|
| ♦ Collector: | ♦ Collection Date: | ♦Collection: ❑ Venipuncture ❑ Capillary ❑ Indwelling Line |
| ♦ Collection Facility/Lab: | ♦ Time: | ❑ Other: |

| **Test Requested**<br>See website for test details, genes, guidelines and sample requirements<br>https://apps.sbgh.mb.ca/labmanual/ | | **Samples Required**<br>Samples must be labeled with patient name and PHIN or equivalent | **Reason for Test**<br>May require prior genetic consultation before testing |
|---|---|---|---|
| □ BRCA1 and BRCA2 (2 Gene Panel) | MD | □ Blood 2x4mL EDTA | □ Confirmation of Clinical Diagnosis |
| □ Hereditary Breast and Ovarian Cancer (10 Gene Panel) | MD | □ DNA 15 µg<br>Minimum concentration 150ng/µL | □ Carrier Status |
| □ Lynch syndrome/Polyposis Panel (12 Gene Panel)<br>Clinical Diagnosis:<br>IHC results (if available): | MD | □ Other:<br>Contact lab prior to ordering | □ Predictive Testing<br>**Clinical Information & Family History** |
| □ PMS2 gene (PMS2 IHC-deficient only) | MD | | Testing will NOT be initiated without this information. Please forward relevant pathology report(s). Please provide pedigree and ethnicity. |
| □ Juvenile Polyposis (BMPR1A and SMAD4) | MD | | |
| □ Single gene analysis: | MD | | |
| □ Other (may require funding approval): | MD | | |
| **Family-Specific Testing** | | | |
| □ Gene:<br>Mutation: | MD | | |
| **Ethnic-Specific Testing** | | | |
| □ Ashkenazi Jewish<br>BRCA1: c.68_69delAG & c.5266dupC<br>BRCA2 c.5946delT | MD | Delphic Barcode Label | **Other family members tested previously:** |
| □ Aboriginal BRCA1 c.1387_1390delAAAAinsGAAAG | MD | | □ No |
| □ Icelandic BRCA2 c.771_775delTCAAA | MD | | □ Yes – Name:<br>Relationship to Patient: |
| □ Mennonite MLH1 c.2141G>A (p.Trp714Ter) | ND | | |