DIAGNOSTIC SERVICES MANITOBA | SERVICES DIAGNOSTIC MANITOBA

Molecular Diagnostic Laboratory: Hereditary Cancer Test Requisition

Fields marked with an asterisk * are mandatory and must be clearly legible. Failure to comply may result in specimen rejection (see DSM policy 10-50-03).

Please have all specimens delivered to:
Health Sciences Centre-Central Services
MS551- 820 Sherbrook St
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
SHIP SAMPLES AT ROOM TEMPERATURE

Additional requisitions and sample requirements available at:
www.dsmanitoba.ca /Medical Practitioners / LIM

ORDERING PROVIDER INFORMATION		PATIENT INFORMATION	
***Last & Full First Name:**	**Billing Code:**	***Last/First Name:** (as per Manitoba Health Card)	
***Ordering Facility:**	**Inpatient Location:**	***Date of Birth:** (dd/mm/yyyy)	**Address:**
Address:		***Sex:** ☐ **Female** ☐ **Male**	
***Critical Results Phone No:**	***Fax No.**	***PHIN:**	
ADDITIONAL COPY OF REPORT (FOR MANITOBA PHYSICIANS ONLY)		***Alternate ID:** (include ID type with number i.e. RCMP, SK, DND, etc.)	***Phone No:**
***Last & Full First Name:**	**Billing Code:**		
***Facility Name:**		**MHSC#:**	**MRN:**
Address:		**Encounter Number:**	
Phone No:	***Fax No.**	**Demographics verified with:**	☐ **Health Card** ☐ **eChart/CR** ☐ **Armband**

CONTACT INFO	COLLECTION INFORMATION	
Clinic/Laboratory Contact Name:	***Collector:**	***Collection Time:** (hh:mm)
Clinic/Laboratory Contact Telephone No :	***Collection Date:** (dd/mm /yyyy)	***Collection Facility/Lab:**

I. Test Requested

See website for test details, guidelines and sample requirements
https://apps.sbgh.mb.ca/labmanual/

☐ Hereditary Breast and Ovarian Cancer panel MD
NGS-*BRCA1, BRCA2, CDH1, PALB2, PTEN, TP53*
MLPA: *BRCA1, BRCA2, CHEK2*

☐ Lynch syndrome MD
Gene(s): _____
IHC results:_____

☐ Familial Adenomatous Polyposis (APC gene) MD

☐ Retinoblastoma (Contact lab prior to drawing) MD

☐ Other (may require funding approval) MD

_____

_____

Family-specific Testing

☐ Gene: _____ MD

Mutation: _____

Ethnic-specific Testing

☐ Ashkenazi Jewish BRCA1: c.68_69delAG & c.5266dupC
BRCA2 c.5946delT MD

☐ Aboriginal BRCA1 c.1387_1390delAAAAinsGAAAG MD

☐ Icelandic BRCA2 c.771_775delTCAAA MD

☐ Mennonite MLH1 c.2141G>A (p.Trp714Ter) MD

Samples Required

Samples must be labeled with patient name and PHN or equivalent

☐ Blood 2x 4 mL EDTA

☐ DNA 15 µg
Minimum concentration 150ng/µL

For other Sample Types ◊:

☐ Tissue
Pathology Reference No.

_____

☐ Other _____

◊ Contact Lab prior to ordering.

Delphic Barcode Label

II. Reason for Test

May require prior genetic consultation before testing.

☐ Confirmation of Clinical Diagnosis

☐ Carrier Status

☐ Predictive Testing

III. Clinical Information and Family History

Testing will NOT be initiated without this information.
Please forward relevant pathology report(s).
Please provide pedigree and ethnicity

Other family members tested previously:
☐ No
☐ Yes Name:_____

Relationship to Patient: _____

Effective Date: 15-OCT-2016
Approved by: P. Chackowsky
(Signature on file)

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