

For PDF Fillable Requisitions, the following applies:

1. The form shall be completed using a Digital Health assigned computer.
2. Absolutely no personal health information shall be electronically saved on a computer.
3. The completed form shall not be shared electronically. If you reasonably believe that e-mailing the information is the only available method of communication or the only way to send the information then you must adhere to the Privacy guideline titled "E-mailing Personal Health Information".
4. All forms must be completed in their entirety, e.g. if a staff member has only completed half of a form they cannot save their work and then come back to complete it at a later date.
5. Once the personal health information has been recorded onto the form, it is to be printed immediately, deleted (not saved) from the computer, and then stored securely inside the client (paper) health record or scanned into an electronic record.
6. Do not print unnecessary duplicate copies of the form.
7. Regular audits of the Digital Health assigned computer shall be undertaken to ensure that no personal health information is being duplicated and saved.

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
SHIP SAMPLES AT ROOM TEMPERATURE

Additional requisitions and sample requirements at:
[Lab Information Manual \(sbgh.mb.ca\)](https://apps.sbgf.mb.ca/labmanual/)
<https://apps.sbgf.mb.ca/labmanual/>

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

Molecular Diagnostic Laboratory – Hereditary Cancer Test Requisition

Ordering Provider Information		Patient Information (print or use addressograph)	
*Last & Full First Name:		Billing Code:	*Last/First Name: (per Health Card)
Inpatient Location:	Critical Results Ph #:		* Date of Birth (dd/mm/yyyy)
*Facility Name/ Address		*Biological Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Ph #:	Fax #:		*PHIN: Specify Province or DND if different
Copy Report To (if info missing, report may not be sent):			
Last & Full First Name:		Billing Code:	MRN:
Ph #:	Fax #:		Encounter #:
Facility Name/ Address:		Patient Ph #:	
Collection Contact Information (Clinic/Laboratory Contact):		Patient Address:	
Demographics verified via: <input type="checkbox"/> Health Card <input type="checkbox"/> Armband <input type="checkbox"/> eChart/CR <input type="checkbox"/> Other			
Collection Information (fields marked with <input type="checkbox"/> required by person collecting sample)			
<input type="checkbox"/> Collector:	<input type="checkbox"/> Collection Date:	Collection: <input type="checkbox"/> Venipuncture <input type="checkbox"/> Capillary <input type="checkbox"/> Indwelling Line <input type="checkbox"/> Other:	
<input type="checkbox"/> Collection Facility/Lab:	<input type="checkbox"/> Time:		
Test Requested	Sample Information	Reason for Test	
See website for test details, genes, guidelines and sample requirements https://apps.sbgf.mb.ca/labmanual/	Samples must be labeled with patient name and PHIN or equivalent	May require prior genetic consultation before testing	
<input type="checkbox"/> BRCA1 and BRCA2 only MD	Has this patient had a bone marrow transplant? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Confirmation of Suspected Clinical Diagnosis <input type="checkbox"/> Predictive Testing <input type="checkbox"/> Carrier Status <input type="checkbox"/> Targeted Drug Therapy <input type="checkbox"/> Ovarian Cancer <input type="checkbox"/> Prostate Cancer <input type="checkbox"/> Other Cancer: _____	
<input type="checkbox"/> 23 Gene Hereditary Cancer Panel MD Reason for testing: <input type="checkbox"/> Hereditary Breast and Ovarian <input type="checkbox"/> GI/Lynch syndrome/Polyposis Panel Clinical Diagnosis: _____ IHC results (if available): _____ <input type="checkbox"/> Other: _____	<input type="checkbox"/> Blood 2x4mL EDTA <input type="checkbox"/> DNA 15 µg Minimum concentration 150ng/µL <input type="checkbox"/> Other (contact lab prior to ordering): _____	URGENT for treatment related decision Date Results Required: _____	
<input type="checkbox"/> PMS2 gene (PMS2 IHC-deficient only) MD	Clinical Information & Family History		
<input type="checkbox"/> Juvenile Polyposis (BMPR1A and SMAD4) MD			
<input type="checkbox"/> Single gene analysis: _____ MD	Testing will NOT be initiated without this information. Please forward relevant pathology report(s). Please provide pedigree.		
Targeted Variants (limited to Genetics)		Ethnicity: _____	
<input type="checkbox"/> BRCA1 and BRCA2 Founder Panel (ethnicity required) MD BRCA1: c.68_69delAG (p.Glu23fs) c.181T>G (p.Cys61Gly) c.1387_1390delinsGAAAG (p.Lys463Glufs*17) c.4035del (p.Glu1346fs) c.4327C>T (p.Arg1443Ter) c.5266dupC (p.Gln1756fs) BRCA2: c.771_775del (p.Asn257fs) c.5238dupT(p.Asn1747Ter) c.5946delT (p.Ser1982fs) c.7443delT (p.Thr2482fs)	Delphic Barcode Label		
<input type="checkbox"/> MLH1 Mennonite c.2141G>A (p.Trp714Ter) MD			
Family-Specific Testing		Other family members tested previously:	
<input type="checkbox"/> Gene: _____ MD Variant: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes – Name: _____ Relationship to Patient: _____		