

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: <small>(as per Manitoba Health Card)</small>			
*Ordering Facility:	Inpatient Location:	*Date of Birth: <small>(dd/mm/yyyy)</small>	Address:		
Address:		*Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male			
*Critical Results Phone No:	*Fax No.	*PHIN:			
ADDITIONAL COPY OF REPORT (FOR MANITOBA PHYSICIANS ONLY)					
*Last & Full First Name:	Billing Code:	*Alternate ID: <small>(include ID type with number i.e. RCMP, SK, DND, etc.)</small>	*Phone No:		
*Facility Name:		MHSC#:	MRN:		
Address:		Encounter Number:			
Phone No:	*Fax No.	Demographics verified with:	<input type="checkbox"/> Health Card <input type="checkbox"/> eChart/CR <input type="checkbox"/> Armband		
CONTACT INFO		COLLECTION INFORMATION			
Clinic/Laboratory Contact Name:	*Collector:	*Collection Time: <small>(hh:mm)</small>			
Clinic/Laboratory Contact Telephone No.:	*Collection Date: <small>(dd/mm/yyyy)</small>	*Collection Facility/Lab:			
I. Test Requested		Samples Required			
See website for test details, guidelines and sample requirements https://apps.sbgh.mb.ca/labmanual/		Samples <u>must</u> be labeled with patient name and PHN or equivalent			
<input type="checkbox"/> Hereditary Breast and Ovarian Cancer panel NGS- <i>BRCA1, BRCA2, CDH1, PALB2, PTEN, TP53</i> MLPA: <i>BRCA1, BRCA2, CHEK2</i> MD <input type="checkbox"/> Lynch syndrome MD Gene(s): _____ IHC results: _____ <input type="checkbox"/> Familial Adenomatous Polyposis (APC gene) MD <input type="checkbox"/> Retinoblastoma (Contact lab prior to drawing) MD <input type="checkbox"/> Other (may require funding approval) MD _____ Family-specific Testing <input type="checkbox"/> Gene: _____ MD Mutation: _____ Ethnic-specific Testing <input type="checkbox"/> Ashkenazi Jewish BRCA1: c.68_69delAG & c.5266dupC BRCA2 c.5946delT MD <input type="checkbox"/> Aboriginal BRCA1 c.1387_1390delAAAinsGAAAG MD <input type="checkbox"/> Icelandic BRCA2 c.771_775delTCAAA MD <input type="checkbox"/> Mennonite MLH1 c.2141G>A (p.Trp714Ter) MD	<input type="checkbox"/> Blood 2x 4 mL EDTA <input type="checkbox"/> DNA 15 µg Minimum concentration 150ng/µL For other Sample Types ◊: <input type="checkbox"/> Tissue Pathology Reference No. _____ <input type="checkbox"/> Other _____ ◊ Contact Lab prior to ordering.	<th style="text-align: center;">II. Reason for Test</th> May require prior genetic consultation before testing. <input type="checkbox"/> Confirmation of Clinical Diagnosis <input type="checkbox"/> Carrier Status <input type="checkbox"/> Predictive Testing <hr/> <th style="text-align: center;">III. Clinical Information and Family History</th> Testing will NOT be initiated without this information. Please forward relevant pathology report(s). Please provide pedigree and ethnicity Other family members tested previously: <input type="checkbox"/> No <input type="checkbox"/> Yes Name: _____ Relationship to Patient: _____		II. Reason for Test	III. Clinical Information and Family History
		<h3 style="margin: 0;">Delphic Barcode Label</h3>			