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.

Molecular Diagnostic Laboratory – Hereditary Cancer Test Requistion

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: 204-787-1384
SHIP SAMPLES AT ROOM TEMPERATURE

Additional requisitions and sample requirements at:
Lab Information Manual (sbgh.mb.ca)

Fields marked with * are mandatory and must be clearly legible or can result in specimen rejection

Ordering Provider Information

*Last & Full First Name: | Billing Code:

*Inpatient Location/Facility Name/Address:

Ph #:

Critical Results Ph #: | Fax #:

Copy Report To *(if info missing, report may not be sent):*

Last & Full First Name: | Ph #: | Fax #:

Facility Name/ Address:

Last & Full First Name: | Ph #: | Fax #:

Facility Name/ Address:

Collection Contact Information (Clinic/Laboratory Contact):

Patient Information ***(print or use addressograph)***

*Last/First Name: (per Health Card)

*Date of Birth (dd/mm/yyyy)

*Sex: □ Female □ Male

*PHIN: Specify Province or DND if different

MRN:

Encounter #:

Demographics verified via:
☐ Health Card ☐ Armband ☐ eChart/CR ☐ Other

Collection Information (fields marked with ☐ required by person collecting sample)

☐ Collector: | ☐ Collection Date:

☐ Collection Facility/Lab: | ☐ Time:

Collection: ❑ Venipuncture ❑ Capillary ❑ Indwelling Line ❑ Other:

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

□ BRCA1 and BRCA2 only MD

□ 24 Gene Hereditary Cancer Panel MD

Reason for testing:
- ☐ Hereditary Breast and Ovarian
- ☐ GI/Lynch syndrome/Polyposis Panel

Clinical Diagnosis: _____

IHC results (if available): _____

- ☐ Other: _____

□ Juvenile Polyposis (BMPR1A and SMAD4) MD

□ Single gene analysis: MD
_____

Targeted Variants (limited to Genetics)

□ 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)

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

Family-Specific Testing

□ Gene: MD
_____

Variant:
_____

Sample Information
Samples must be labeled with patient name and PHIN or equivalent

Has this patient had a bone marrow transplant? □ Yes □ No

□ Blood 2x4mL EDTA

□ DNA 15 µg
Minimum concentration 150ng/µL

□ Other (contact lab prior to ordering): _____

Reason for Test
May require prior genetic consultation before testing

- □ Confirmation of Suspected Clinical Diagnosis
- □ Predictive Testing
- □ Carrier Status
- □ Targeted Drug Therapy
  - ☐ Ovarian Cancer
  - ☐ Prostate Cancer
  - ☐ Other Cancer: _____

URGENT for treatment related decision
Date Results Required: _____

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

Ethnicity: _____

Other family members tested previously:

- □ No
- □ Yes – Name: _____

Relationship to Patient: _____