

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.

KR-001 MOLECULAR PATHOLOGY TEST REQUISITION FORM

Delphic Label

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

*****Please Complete the Information Below. Print Clearly. Check Appropriate Profile*****

CCMB to complete and FAX to Client Services: 204-940-2519			CCMB to Complete: Patient Information		
*Provider Last & Full First Name:		Billing Code:	*Last/First Name: (per Health Card)		
*Facility Name & Address:			* Date of Birth (dd/mm/yyyy)		
Phone Number:		Fax No:	*Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male		
Physician Signature:			*PHIN: Specify if other province/ DND)		
CCMB CR# _____			MRN:		
CCMB Fax @ 204-786-0631			Encounter Number:		
			Patient Phone No:		
			Patient Address:		

Test Name	Testing Site	LIS Code	IHC Test Name (in-house)	Testing Site	LIS Code
<input type="checkbox"/> Q31 HotSpot Tumour Panel	SH	Q31	<input type="checkbox"/> PD-L1 send out	Dynacare	PDLS0
<input type="checkbox"/> ALK	SH	ALKA	<input type="checkbox"/> PD-L1 Head and Neck	SH	PDLHN
<input type="checkbox"/> NTRK	Lifelabs	NTRK	<input type="checkbox"/> PD-L1 Lung	SH	PDL1 AW
			<input type="checkbox"/> Triple Negative Breast-PD-L1	Dynacare	TNBC
<input type="checkbox"/> EGFR p.T790M mutation only (Circulating tumor DNA)	UHN	EGFR	<input type="checkbox"/> Her2 IHC	SH	HR2
<input type="checkbox"/> Mismatch Repair (MMR IHC)	SH	MMR	<input type="checkbox"/> Estrogen Receptor - Breast Ca	SH	ERV AT
<input type="checkbox"/> MSI Testing	SH	MSIP	<input type="checkbox"/> Progesterone Receptor - Breast Ca	SH	PRV AT
<input type="checkbox"/> BRAF V600E IHC	SH	BRAF AR	<input type="checkbox"/> BRCA 1/2 Somatic	SH	BRCA
<input type="checkbox"/> FoundationOne	Foundation Medicine (USA)	N/A	<input type="checkbox"/> OncoType DX (breast ca)	Genomic	ONDX
<input type="checkbox"/> Other:			<input type="checkbox"/> Ki-67	SH	Ki-67
Pathology Case #:			Diagnosis:		
Gene of Interest:			Stage:		
Previous Testing:			Date Requested:		
*Indication for testing: _____					

LAB Use Only	
Index Pathologist Name: _____ Pathology Site: <input type="checkbox"/> HSC <input type="checkbox"/> GGH <input type="checkbox"/> SBH <input type="checkbox"/> Westman Lab <input type="checkbox"/> Dynacare <input type="checkbox"/> Other: _____ Selected Block ID: _____	Q31 Hotspot SAMPLE <input type="checkbox"/> Formalin-fixed paraffin-embedded tissue punch: _____ % Tumour Cellularity: _____ % Necrosis: _____ <input type="checkbox"/> Send for Secondary Assessment _____
Sample Harvested by: _____ Date: _____ Comments: _____	