Reset Form

Trillium Health Partners

THP MOLECULAR ONCOLOGY & HEMATOLOGY TESTING REQUISITION

GENETICS LABORATORY - Credit Valley Hospital
2200 Eglinton Ave. W., Rm 2H144 *Tel: (905) 813-1100 x6288*
Mississauga, ON L5M 2N1 Canada *Fax: (905) 813-3854*

Patient Acct No.

Patient Name (Surname First) **D.O.B** **Sex**

Patient Unit No.

Address/City/Postal Code

Health Card Number **Version** ☐ WCB ☐ SELF PAY

Complete in full to avoid delay in reporting result.

PHYSICIAN INFORMATION

Referring Physician: _____
Registration #: _____
Address: _____
Phone: _____ Fax: _____
Signature *(required)*: _____

Copy To: _____
Registration #: _____
Address: _____
Phone: _____
Fax: _____

SPECIMEN COLLECTION: **DATE:** _____ **TIME:** _____
DD/MM/YYYY HH:MM

Specimen # / Block # : _____
Attach corresponding pathology report

Specimen Submitted:
☐ Paraffin-Embedded Tissue (circled H&E required) *Tumour Cellularity (%) within circled region:* _____
☐ Cytology Specimen (H&E required) *Tumour Cellularity (%):* _____
☐ Blood (5-10mL **EDTA**, Room Temperature)
☐ Bone Marrow (**EDTA**, Room Temperature, attach CBC report)
☐ DNA

~ Please contact the lab for specimen requirements ~

TEST REQUESTED

Solid Tumour Molecular Assays:

Lung
☐ *EGFR* – baseline
☐ *EGFR* – T790M Resistance Mutation

Colorectal
☐ *BRAF/ NRAS/ KRAS*
☐ *BRAF/MLH1* Methylation Studies

Endometrial
☐ *MLH1* Methylation Studies

Melanoma
☐ *BRAF/ NRAS/ KIT*

Hairy Cell Leukemia
☐ *BRAF*

Brain
☐ MGMT

Paraffin FISH Assays:

☐ Her2neu
☐ ALK
☐ 1p / 19q
☐ MYC
☐ IGH / BCL2
☐ BCL6

Molecular Hematological Assays:

☐ JAK2 / CALR
☐ T cell Clonality
☐ B cell Clonality
☐ CML – Diagnostic
☐ CML – MRD Follow Up
*** must receive within 24 hrs of collection, along with CBC report*
☐ Thrombophilia (Factor V, Prothrombin)
☐ Hemochromatosis

LAB USE ONLY

Date Recieved (DD/MM/YYYY): _____ **Time:** _____ **Tech:** _____
Specimen Received: _____
Comments: _____
Unit #: _____ **LAB #:** _____

3978 D (July/2017)