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THE HOSPITAL FOR SICK CHILDREN
Paediatric Laboratory Medicine

555 University Avenue
Room 3416, Roy C. Hill Wing
Toronto, ON, M5G 1X8, Canada

Tel: 416-813-7200 x1
Fax: 416-813-7732
(CLIA # 99D1014032)

Genome Diagnostics – Cancer Testing

www.sickkids.ca/genome-diagnostics

Last Name:
First Name:
Date of Birth (DD/MM/YYYY):
Legal Sex: ◯ *Male* ◯ *Female* ◯ *Non-binary/U/X*
Sex Assigned at Birth (if different): ◯ *Male* ◯ *Female* ◯ *Unassigned*
Gender Identity: ◯ *Male* ◯ *Female* ◯ *Non-binary/U/X*
Parent's Name:
Address:
MRN #:

For Canada Only
Provincial Health Card #: *Version:*
Issuing Province:

Testing is provided for medical purposes only and results are not intended for forensic use. The laboratory is not a forensically accredited laboratory.

Referring Physician:

Name: _____

Institution: _____

Address: _____

_____

Phone: _____ Fax: _____

Email address: _____

Signature *(required)*: _____

Copy Report To:

Name: _____

Address: _____

Phone: _____ Fax: _____

Sample Information:

Date obtained (DD/MM/YYYY): ____/____/____

Your referring laboratory reference #:

☐ Blood in EDTA (purple top tube): min. 4 mL

☐ DNA: min. 200 ug in low TE buffer (Source: _____)

☐ Tissue (Source: _____)

☐ Other (Specify: _____)

Pathology Specimen ID: _____

Tumour Cellularity (%): _____

Closed consent:

☐ If checked, all remaining DNA will be discarded upon notification by the ordering physician that all DNA testing has been completed

Responsible Pathologist:

Name: _____

Address: _____

Your referring laboratory reference # : _____

Phone: _____ Fax: _____

Laboratory Use

Date (DD/MM/YYYY) | **Time Received: Germline**
____/____/____h

Date (DD/MM/YYYY) | **Time Received: Tumour**
____/____/____h

Lab ID (Germline/Tumour): _____

Specimen type, amt & # of tubes: _____

Germline: _____

Tumour: _____

Patient ID: _____

Test request/ICD-O code *(write below and/or check box(es) on pages 2):*

_____

Reason for Testing:

☐ Tumour and Germline Testing ☐ Germline testing only

☐ Familial mutation/variant analysis ☐ Follow up testing (disease progression, relapse)

☐ Bank DNA only

☐ Other (Specify): _____

If expedited testing is requested, please indicate reason

☐ Treatment/management: _____

☐ Other (Specify: _____)

Familial Mutation/Variant Analysis:

For prenatal testing and cases where a familial mutation or variant is known, please complete below and attach a copy of the proband's report:

Gene/Transcript: _____

Mutation/variant(s) (c., p. and/or g.) _____

SickKids order number: _____

SickKids family number: _____

Name of proband: _____

Relationship to proband: _____

Clinical Diagnostics and Family History:

Ethnicity of patient: _____

Known family history? ☐ Yes ☐ No ☐ Unknown

Age at diagnosis: _____

Please draw or attach a pedigree and provide any relevant information below, including clinical and family history details, as this is important for accurate interpretation of results. Refer to Page 3 for additional space.

Ordering Checklist:

☐ Specimen tube labeled with at least two identifiers

☐ Completed test requisition form *(pages 1-4)*
Clinical information must be provided on pages 2 -3 for all Next-Generation Sequencing tests. Testing will not proceed until these are provided.

☐ Completed billing form *(page 4, if applicable)*

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LIST OF CANCER TESTING AVAILABLE
For current list of genes please visit: http://www.sickkids.ca/genome-diagnostics

Select tumour type:

Solid tumour

Select tumour type:

- ☐ Colon adenocarcinoma - C18-C20-8140/3
- ☐ Desmoid tumour - 8821/1
- ☐ Ewing Sarcoma - 9260/3
- ☐ Malignant peripheral nerve sheath tumour - 9540/3
- ☐ Medullary carcinoma - 8510/3
- ☐ Nephroblastoma (Wilms tumour) - 8960/3
- ☐ Neuroblastoma - 9500/3
- ☐ Osteosarcoma - 9180/3
- ☐ Papillary carcinoma - 8050/3
- ☐ Rhabdomyosarcoma (NOS-8900/3, Embryonal-8910/3 or Alveolar-8920/3)
- ☐ Synovial sarcoma - 9040/3
- ☐ Other; Specify ICD-O code*: (_____)

CNS tumour

Select tumour type:

- ☐ Astrocytoma - 9400/3
- ☐ Ependymoma - 9391/3
- ☐ Glioblastoma - 9440/3
- ☐ Medulloblastoma - 9470/3
- ☐ Primitive neuroectodermal tumour - 9473/3
- ☐ Other; Specify ICD-O code*: (_____)

Hematological malignancy

Select tumour type:

- ☐ Acute lymphoblastic leukemia - 9826/3
- ☐ B-cell lymphoblastic leukemia/lymphoma - 9811/3
- ☐ T-cell lymphoblastic leukemia/lymphoma - 9837/3
- ☐ Acute Myeloid Leukemia
- ☐ Chronic Myeloid Leukemia - 9863/3
- ☐ Hodgkin Lymphoma - 9650/3
- ☐ Non-Hodgkin Lymphoma - 9591/3
- ☐ Mediastinal large cell lymphoma - 9679/3
- ☐ Other; Specify ICD-O code*: (_____)

Select test type:

Tumour and Germline testing:

Comprehensive testing includes clinically actionable genes with strong evidence for association with cancer and predisposition to cancer.

- ☐ **Comprehensive Cancer Panel analysis (864 genes)**

Germline only testing:

Comprehensive Cancer Predisposition testing includes clinically actionable genes with strong evidence for association with cancer predisposition.

- ☐ **Comprehensive Cancer Predisposition analysis (864 genes)**

* **ICD-O codes available at: http://codes.iarc.fr**

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ADDITIONAL RELEVANT CLINICAL INFORMATIONs

FAMILY HISTORY

Please draw or attach a pedigree and provide any relevant information below, including clinical and family history details, as this is important for accurate interpretation of results.

Previous Genetic Testing:

☐ No

☐ Yes; Specify Test Results:

OTHER CLINICAL OR PATHOLOGICAL INFORMATION:

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Completion of Billing Form NOT required for patients with an Ontario Health Card Number.

BILLING FORM

At your direction, we will bill the hospital, referring laboratory, referring physician, or a patient/guardian, for the services we render

- Invoices are sent upon completion of each test/service.
- Invoices are itemized and include the date of service, patient name, CPT code, test name and charge.
- Contact SickKids' Genome Diagnostics Laboratory at 416-813-7200 x1 with billing inquiries.

How to complete the Billing Form:

- **Referring Physician completes the appropriate section below to specify billing method.**
- **Send requisition and completed "Billing Form" with specimen.**

Section 1: Complete to have the Healthcare Provider billed:

Your Referring Laboratory's Reference #:_____Billing address

of hospital, referring laboratory, clinic, referring physician, or medical group: (if different from requisition):

Name: _____

Address: _____

City: _____Prov/State: _____

Postal/Zip Code:_____Country: _____

Contact Name:_____Contact Telephone #: _____

Section 2: Complete to have Patient/Guardian billed directly:

If you elect to have patient/guardian billed:

- *Patient/Guardian billing information below must be complete; otherwise, the healthcare provider will be billed.*
- *Please advise the patient/guardian to expect a bill from our laboratory.*
- *Provide us with patient's valid credit card information.*
- *Unfortunately, we cannot accept personal checks.*
- ***In this case, the patient/guardian is solely responsible for the charges.***

Send bill to (check one): ☐ Patient ☐ Guardian

Method of Payment (check one): ☐ American Express ☐ MasterCard ☐ Visa

Name as it appears on credit card: _____

Credit card # : _____

Expiry date on credit card: _____

Signature of credit card holder (Required): _____

Mailing Address of Patient/Guardian (if different from requisition):

Name: _____

Address: _____

_____ Apt. #: _____

City:_____Prov/State: _____

Postal/Zip Code:_____Country: _____

Additional Contact Information

Patient's phone # with area code:

_____

- or -

Guardian's phone # with area code:

_____