ALBERTA PRECISION LABORATORIES
Leaders in Laboratory Medicine

Molecular Genetics Laboratory
Cancer and Endocrine NGS Requisition

*For detailed testing information, refer to **APL Genetics & Genomics Webpage** http://ahsweb.ca/lab/if-lab-genetics-and-genomics and **APL Test Directory** http://ahsweb.ca/lab/apl-td-lab-test-directory*

Scanning Label or Accession # *(lab only)*

Patient

PHN Expiry: _____		Date of Birth *(dd-Mon-yyyy)*		
Legal Last Name		Legal First Name	Middle Name	
Alternate Identifier	Preferred Name	☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to disclose	Phone	
Address		City/Town	Prov	Postal Code

Provider(s)

Authorizing Provider Name *(last, first, middle)*			Copy to Name *(last, first, middle)*	Copy to Name *(last, first, middle)*
Address		Phone	Address	Address
CC Provider ID	CC Submitter ID	Legacy ID	Phone	Phone
Clinic Name			Clinic Name	Clinic Name

Collection

Date *(dd-Mon-yyyy)*	Time *(24 hr)*	Location	Collector ID

Genetic Counsellor/Clinic Contact Name *(last, first)*	Phone

Specimen

☐ Whole Blood in EDTA tube ☐ Extracted DNA ☐ Fluid, amniotic*

☐ Tissue, chorionic villi* ☐ Cord blood* ☐ Other *(specify)* _____

*If specimen type is prenatal or cord blood, maternal specimen must be collected for maternal cell contamination studies

Health Care Provider Important Information

1. All sections of the requisition must be completed.
2. By providing this requisition to the patient/family, the health care provider confirms that they have reviewed the pre-test counselling information (available on the Genetics & Genomics website) with the patient/family, and the patient/family consents to testing.
3. Direct patient to take requisition to a local blood collection location to have blood specimen drawn.

Billing Information: Must be completed if the patient does not have a valid Alberta Personal Heath Number

Genetic testing is not covered by inter-provincial billing agreements. Alberta Precision Laboratories (APL) will bill a provincial medical services plan provided there is a letter of pre-approval received with the requisition or Institutional Billing information provided below. By completing the Institutional Billing section, the health care provider confirms they have obtained any necessary pre-approval. For patient pay, contact the testing laboratory.

Institutional Billing Information ***(if pre-approval letter not attached)***	
Address	
Contact Name *(last, first)*	
Phone	Fax

MGL Use Only

Patient Number	Family Number	Received	Quantity

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PHN	

Section I - Reason for Testing *(Select one only)*

☐ **Confirmation of Diagnosis**
Patient has signs or symptoms of the disease / disorder.

☐ **Presymptomatic or Predictive Testing**
Patient does not presently have symptoms; positive family history

☐ **Carrier Testing**.
No symptoms; at risk of being a carrier of a recessive disorder

☐ **Required for Family Study**

☐ **Prenatal Testing**

☐ **Other** _____

Section II - Family History of Indicated Disease

☐ Unknown family history

☐ No known family history

☐ Possible family history

Documented family history

☐ Clinical Diagnosis ONLY

☐ Molecular Diagnosis *(provide a copy of the familial variant report and complete information in Section V)*

Is RUSH testing needed? ☐ Yes *(provide details below)*

☐ Results will alter the **immediate** management and/or treatment of this patient *(specify)* _____

☐ Results will impact an ongoing pregnancy *(provide EDD, and procedure date if applicable)* _____

If RUSH testing is required, please provide a target date *(dd-Mon-yyyy) (required)* _____

Note: TAT is a minimum of 4 weeks.

Section III - Patient Clinical Information

Sex at birth ☐ Female ☐ Male ☐ Unknown

Date of last chemotherapy *(if applicable)* → Date *(dd-Mon-yyyy)* _____

Has this patient received a blood product in the preceding three months?
☐ Yes indicate blood product _____

Has the patient had a bone marrow transplant? ☐ Yes ***(Blood is an incompatible specimen type)***

Please provide any relevant information regarding your patient's clinical presentation *(ex. tumour site, age at diagnosis, multiple primary tumour, pathology, hormone receptors)*

If applicable, IHC result *(required for Lynch testing)* _____

Has the patient had *BRCA 1/2* testing of tumour tissue? _____

Section IV - Pedigree

(Provide any relevant family history details, with family member names, ages, and diagnoses included as applicable. If more space is required, attach a separate sheet.)

Patient Ethnicity/Ancestry _____

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Section V - Specific Variant Testing

Complete this section only if you are requesting testing for a variant previously identified in the family.
Specific variant testing is available for all genes available on the panels listed below.

☐ Inherited Cancer and Endocrine Gene Panels, Specific Variant

Gene	Mutation/Variant

Relationship to index patient _____

What is the phenotype/presentation in the index patient? _____

Other family members previously tested in MGL ☐ No ☐ Yes ▼

INDEX patient name	MGL Reference Number

Which laboratory performed the proband testing? ☐ Calgary ☐ Edmonton ☐ Other *(specify)* _____

Testing a positive control is recommended if the proband testing was performed at another lab.
A clear copy of the test report on a family member is required if the testing was performed at another laboratory

Section VI - Cancer and Endocrine NGS Panel Requests

Breast, Ovarian and Prostate Cancers
- ☐ Breast/Ovarian/Prostate Cancer Panel

Endocrine Disorders
- ☐ Endocrine Neoplasia Panel
- ☐ Paraganglioma/Pheochromocytoma Predisposition Panel
- ☐ Renal Cancer Panel

Gastrointestinal Cancers
- ☐ Gastrointestinal/Polyposis Panel
- ☐ Gastrointestinal Stromal Tumor Panel
- ☐ Lynch Syndrome Panel
- ☐ Pancreatic Cancer Panel

Hematological Cancers
- ☐ Familial Acute Myeloid Leukemia Panel
- ☐ Fanconi Anemia and DNA Repair Disorders Panel

Overgrowth Disorders
- ☐ Hereditary Multiple Osteochondromatosis Panel
- ☐ Overgrowth Panel

Pediatric Cancers
- ☐ Pediatric Cancer Panel
- ☐ Schwannomatosis Panel
- ☐ Tuberous Sclerosis

Skin Cancers
- ☐ Skin Cancer Panel
- ☐ Xeroderma Pigmentosum Panel

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Section VII - Single Gene Test Request

☐ *CASR*-Related Disorder

☐ Inherited Cancer and Endocrine Single Gene *(complete only if panel is not appropriate for patient)*

Requesting test for _____ *(indicate the gene)* **and** the presenting phenotype _____

Requesting test for _____ *(indicate the gene)* **and** the presenting phenotype _____

☐ Neurofibromaosis Type 1 ***Please indicate if your patient has the following***

- ☐ Greater than 6 café-au-lait macules greater than 5 mm, postpubertal greater than 15 mm
- ☐ Greater than 2 neurofibromas or 1 plexiform neurofibroma
- ☐ Axillary or inguinal freckling
- ☐ Optic glioma
- ☐ Greater than 2 Lisch nodules
- ☐ A distinctive osseous lesion
- ☐ A first degree relative with NF1 per the above critera

If the patient does not fulfill NIH diagnostic criteria for NF1, please provide reason for testing as a comment

_____

Section VIII - Variant Reinterpretation

Complete this section only if you are requesting reinterpretation of a variant previously identified in the family

Gene	Mutation/Variant
What is the clinical phenotype/presentation in the family?	

A clear copy of the test report is required if the testing was preformed at another laboratory

Section IX - Additional Comments