Sinai Health | Mount Sinai Hospital
Joseph & Wolf Lebovic Health Complex

Advanced Molecular Diagnostics
Pathology and Laboratory Medicine,
Room 11D.410, 600 University Ave,
Toronto, Ontario, Canada, M5G 1X5
Tel: (416) 586-4800 x 5974
Fax: (416) 586-8395

# Molecular Genetics Requisition

PATIENT INFORMATION (PLACE LABEL HERE or TYPE)
Last Name: _____
First Name: _____
MRN: _____
Date of Birth: _____
Address: _____
*Province:* _____ Health Card & Version Code_____
Sex (OHIP): Male ☐ Female ☐
Sex assigned at birth: Male ☐ Female ☐

| REFERRING PHYSICIAN (Please type or print in CAPS) | | GENETIC COUNSELLOR: (Please type or print in CAPS) | |
|---|---|---|---|
| Name: | | Name: | |
| Institution: | | Institution: | |
| Address: | | Address: | |
| City: | Postal Code: | City: | Postal Code: |
| Tel: | Fax: | Tel: | Fax: |
| Email: | | Email: | |
| Signature & CPSO (required): | | Additional Copy To: | |

## SPECIMEN INFORMATION

*Preferred specimen type is blood in EDTA. Fresh blood is required for all MLPA requests.*

☐ Blood (EDTA lavender top – 2x 5 mL tubes) ☐ DNA ☐ Banked DNA GP# (if known):_____ ☐ Other (Specify): _____
Date collected: _____ Time collected: _____ Location: _____ Phlebotomist's initials: _____

☐ Formalin-Fixed Paraffin-Embedded (FFPE) Paraffin Block(s): Surgical #: _____
Hospital Name & Address: _____
Tissue Type: _____ Previous MSH Genetics Report # or ID#: _____

*Please attach a copy of the original pathology report*

## REASON FOR REFERRAL

☐ Diagnostic Evaluation ☐ Pharmacogenetic Testing
☐ Carrier Screening ☐ Targeted Variant Testing (complete below)
☐ Bank DNA
☐ Variant Re-assessment: MSH Case #: _____ (complete below)

## SPECIAL INSTRUCTIONS (Optional)

_____
_____
_____

☐ Send Out Test Name: _____ Please indicate DNA requirement: _____ *Note: if >10ug provide a 10 ml blood sample*
**Please attach outside laboratory requisition*
Shipment & Billing Information: _____ Courier or waybill #: _____

☐ ROUTINE ☐ EXPEDITE (Reason): _____ Date of procedure: _____
*Note: only cases requiring immediate medical management will be expedited*

## PATIENT CLINICAL INFORMATION (Page 2 can be used optionally to include more detailed information)

Disease Status: ☐ Unaffected ☐ Unknown ☐ Affected - Disease Type and age of diagnosis:_____
Additional Information (ie: Pathology or IHC results):_____
_____

Family History of disease: ☐ Positive (Please attach pedigree) If positive, list relevant diseases:_____
☐ Negative Ethnicity:_____

## GENETIC TEST REQUEST (Pages 3-5 can be used optionally)

| Test Code | Gene Panel/Syndrome Name | Number of genes |
|---|---|---|
| | | |
| | | |

## Targeted Variant Testing (Test Code: TAVT1)

Gene: _____ Exon: _____ Variant: _____ Reference Sequence: NM_____
*(HGVS nomenclature or indicate if other. If requesting multiple variant please complete on page 5 )*

For targeted variant include: Proband Name: _____ DOB: _____ Relationship to Patient: _____ MSH Report# : _____
**If proband testing was performed elsewhere, please attach a copy of the original result (ALL pages) and send positive control sample if available*

| MSH MOLECULAR LABORATORY USE: | | ORDERING CHECKLIST |
|---|---|---|
| **# of Tubes:** | **Family#** | |
| **Lab #:** | **Sample Label:** | ☐ Completed Requisition - clinical information (minimum page 1) |
| **GP#:** | | ☐ Specimen labeled (with at least two identifiers) |
| **Date Received/Tech Initial:** | | ☐ Pedigree attached OR clinical report documentation |
| | | ☐ Familial testing - Reference sequence / positive control |

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## PATIENT CLINICAL INFORMATION

DISEASE STATUS ☐ Affected ☐ Unaffected ☐ Unknown

☐ **Breast Cancer** Age of diagnosis:_____ ☐Bilateral ☐ Two Primary ☐ TNBC ☐ DCIS ☐ IDC ☐ LCIS ☐ ILC (type_____)

☐ **Ovarian Cancer** Age of diagnosis:_____ ☐Serous ☐ Endometrioid ☐Mucinous ☐Clear Cell ☐Borderline

☐ **Colon Cancer** or
☐ **Endometrial Cancer**
Age of diagnosis:_____
MSI result: ☐ High ☐ Low ☐ Stable ☐ Unknown
IHC result: ☐ Intact ☐ *MLH1* Def ☐ *MSH2* Def ☐ *MSH6* Def ☐ *PMS2* Def ☐ Unknown

☐ **Other Cancer** Type:_____ For Sarcoma, please indicate sub-type:_____

☐ **Polycystic Kidney Disease**
Age of diagnosis: _____ Total Kidney Volume:_____ ☐On dialysis - age initiated: _____
☐Bilateral multicystic kidneys ☐Unilateral Kidney Cysts ☐Segmental Kidney Cysts ☐Intracranial Aneurysm
☐ Extra Renal Cysts: Location:_____

**Additional Relevant Information:**

_____
_____
_____
_____
_____
_____
_____
_____
_____

## PATIENT FAMILY HISTORY

**RACE & ETHNICITY:** Please check ALL that apply
☐ White ☐ Asian ☐ Hispanic ☐ Black/African Descent ☐ Ashkenazi Jewish ☐ Other (specify) _____

☐ Indigenous Specify Nation/ tribe/band/community:_____

**FAMILY HISTORY:** ☐ NO ☐ YES Please include a three generation pedigree (or draw below):

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| HEREDITARY CANCER PANEL TESTING | | |
|---|---|---|
| **Gene Panel Name (# genes)** | **Test Code** | **Genes** |
| ☐ Hereditary Breast/ Ovarian/ Prostate Cancer (19) | HBOP1 | *ATM, BARD1, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, EPCAM, MLH1, MSH2, MSH6, PALB2, PMS2, PTEN, RAD51C, RAD51D, STK11, TP53, HOXB13* |
| ☐ Hereditary Breast/ Ovarian/ Prostate/ Gastrointestinal Cancer (36) | BOPG2 | *APC, ATM, BARD1, BMPR1A, BRCA1, BRCA2, BRIP1, CDH1, CDKN2A, CHEK2, CTNNA1, EPCAM, GALNT12, GREM1, MLH1, MLH3, MSH2, MSH3, MSH6, MUTYH, NTHL1, PALB2, PMS2, POLD1, POLE, PTEN, RAD51C, RAD51D, RNF43, RPS20, SDHB, SDHD, SMAD4, STK11, TP53, HOXB13* |
| ☐ Hereditary Breast/ Ovarian/ Prostate/ Melanoma Cancer (24) | BOPM1 | *ATM, BAP1, BARD1, BRCA1, BRCA2, BRIP1, CDH1, CDK4, CDKN2A, CHEK2, EPCAM, MITF, MLH1, MSH2, MSH6, PALB2, PMS2, POT1, PTEN, RAD51C, RAD51D, STK11, TP53, HOXB13* |
| ☐ Hereditary Endometrial Cancer (10) | HEEN1 | *BRCA1, BRCA2, EPCAM, MLH1, MSH2, MSH6, PMS2, POLD1, POLE, PTEN* |
| ☐ Hereditary Gastrointestinal Cancer (Lynch Syndrome, Gastric, Pancreas, Polyposis, 31) | HEGI2 | *APC, ATM, BMPR1A, BRCA1, BRCA2, CDH1, CDKN2A, CHEK2, CTNNA1, EPCAM, GALNT12, GREM1, MLH1, MLH3, MSH2, MSH3, MSH6, MUTYH, NTHL1, PALB2, PMS2, POLD1, POLE, PTEN, RNF43, RPS20, SDHB, SDHD, SMAD4, STK11, TP53* |
| ☐ Hereditary Gastric Cancer (17) | GAST1 | *APC, ATM, BRCA1, BRCA2, CDH1, CTNNA1, EPCAM, MLH1, MSH2, MSH6, PALB2, PMS2, SDHB, SDHD, SMAD4, STK11, TP53* |
| ☐ Lynch Syndrome (5) | LYNS1 | *EPCAM, MLH1, MSH2, MSH6, PMS2* |
| ☐ Hereditary Pancreatic Cancer (Adenocarcinoma, 12) | PANC1 | *ATM, BRCA1, BRCA2, CDKN2A, EPCAM, MLH1, MSH2, MSH6, PALB2, PMS2, STK11, TP53* |
| ☐ Hereditary Polyposis (21) | POLY2 | *APC, BMPR1A, EPCAM, GALNT12, GREM1, MLH1, MLH3, MSH2, MSH3, MSH6, MUTYH, NTHL1, PMS2, POLD1, POLE, PTEN, RNF43, RPS20, SMAD4, STK11, TP53* |
| ☐ Familial Gastrointestinal Stromal Tumour (7) | FAGS1 | *KIT, PDGFRA, SDHA, SDHAF2, SDHB, SDHC, SDHD* |
| ☐ Familial Melanoma (7) | FAME1 | *BAP1, BRCA2, CDK4, CDKN2A, MITF, POT1, PTEN* |
| ☐ Familial Renal Cancer (15) | FARE1 | *BAP1, FH, FLCN, MET, MITF, PTEN, SDHA, SDHAF2, SDHB, SDHC, SDHD, TP53, TSC1, TSC2, VHL* |
| ☐ Hereditary Pheochromocytoma and Paraganglioma (12) | HPP1 | *FH, MAX, MEN1, NF1, RET, SDHA, SDHAF2, SDHB, SDHC, SDHD, TMEM127, VHL* |
| ☐ Hereditary Central Nervous System Tumour (20) | CENS1 | *APC, EPCAM, LZTR1, MLH1, MSH2, MSH6, NF1, NF2, PMS2, POLE, POT1, PTCH1, PTEN, SMARCB1, SMARCE1, SUFU, TP53, TSC1, TSC2, VHL* |
| ☐ Hereditary Soft Tissue Tumour (12) | SOTI1 | *APC, ATM, BRCA1, BRCA2, CHEK2, EPCAM, MLH1, MSH2, MSH6, NF1, PMS2, TP53* |
| Gene panels include both sequencing and deletion/duplication analysis with the exception of *GREM1* and *EPCAM* which are analyzed for large deletions/duplications only. *HOXB13* and *APC* GAPPS variant analysis will be targeted to known pathogenic variants. | | |

| TARGETED HEREDITARY CANCER GENETIC TESTING | | |
|---|---|---|
| **Panel Name** | **Test Code** | **Targeted Variants** |
| ☐ Ashkenazi Jewish Cancer Panel | AJC01 | NM_000038.6(*APC*):c.3920T>A (p.Ile1307Lys), APC I1307K<br>NM_007294.4(*BRCA1*):c.68_69del (p.Glu23fs), BRCA1 (185delAG or 187delAG)<br>NM_007294.3(*BRCA1*):c.5266dup (p.Gln1756Profs), BRCA1 (5382insC or 5385insC)<br>NM_000059.4(*BRCA2*):c.5946del (p.Ser1982fs), BRCA2 (6174delT)<br>NM_007194.4(*CHEK2*):c.1283C>T (p.Ser428Phe)<br>NM_013372.7 *GREM1* 40 kb dup<br>NM_000251.2(*MSH2*):c.1906G>C (p.Ala636Pro),<br>NM_000179.2 (*MSH6*):c.3984_3987dup (p.Leu1330Valfs)<br>NM_000179.2(*MSH6*):c.3959_3962del (p.Ala1320Glufs) |
| Analysis is limited to the targeted variants above. | | |

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| HEREDITARY CANCER SINGLE GENE SYNDROMES OR SMALL GENE PANELS | | |
|---|---|---|
| **Syndrome** | **Test Code** | **Associated Genes** |
| ☐ AXIN2-related Attenuated Familial Adenomatous Polyposis | AFAP1 | *AXIN2* |
| ☐ BAP1 Tumour Predisposition Syndrome | BTPS1 | *BAP1* |
| ☐ Birt-Hogg-Dube Syndrome | BHDU1 | *FLCN* |
| ☐ Carney Complex | CACO1 | *PRKAR1A* |
| ☐ Familial Adenomatous Polyposis | CTDA1 | *APC* |
| ☐ Familial Adenomatous Polyposis with *MUTYH* | TDAM1 | *APC, MUTYH* |
| ☐ DICER-associated Syndrome | DIAS1 | *DICER1* |
| ☐ Dysplastic Nevus Syndrome | DYNS1 | *CDK4, CDKN2A* |
| ☐ Familial Isolated Pituitary Adenoma | FIPA1 | *AIP* |
| ☐ Hereditary Hyperparathyroidism | HEHY1 | *CDC73, MEN1* |
| ☐ Hereditary Leiomyomatosis and Renal Cell Cancer | HLRC1 | *FH* |
| ☐ Hereditary Lung Cancer | HELC1 | *EGFR* (T790M; V834I; V769M) |
| ☐ Li-Fraumeni Syndrome | LIFS1 | *TP53* |
| ☐ MEN1 Syndrome | MENS1 | *MEN1, CDKN1B* |
| ☐ Multiple Endocrine Neoplasia Type 2 | ENEO1 | *RET* |
| ☐ Neurofibromatosis, type 1 | NUEF1 | *NF1* |
| ☐ Nevoid Basal Cell Carcinoma Syndrome/ Gorlin Syndrome | NBCC1 | *PTCH1, SUFU* |
| ☐ Nijmegen Breakage Syndrome | NIBS1 | *NBN* |
| ☐ Peutz-Jeghers Syndrome | PEJS1 | *STK11* |
| ☐ PTEN Hamartoma Tumour Syndrome | PHTS1 | *PTEN* |
| ☐ Rare Polyposis Genes | RAPG1 | *GALNT12, RPS20* |
| ☐ Retinoblastoma | RETB1 | *RB1* |
| ☐ Rhabdoid Predisposition Syndrome | RHPS1 | *SMARCA4, SMARCB1* |
| ☐ Schwannomatosis | SCHW1 | *NF2, LZTR1, SMARCB1* |
| ☐ Sessile Serrated Polyposis Cancer Syndrome | SSPC1 | *RNF43* |
| ☐ Small Cell Carcinoma of the Ovary, Hypercalcemic Type (SCCOHT) | SSCO1 | *SMARCA4* |
| ☐ Tuberous Sclerosis | TUBS1 | *TSC1, TSC2* |
| ☐ Von Hippel-Lindau Syndrome | VHLS1 | *VHL* |
| Single gene and small gene panels include both sequencing and deletion/duplication analysis unless otherwise stated. | | |

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Sex assigned at birth: Male ☐ Female ☐

## ADDITIONAL TESTING

### TARGETED VARIANT TESTING (Test Code: TAVT1)

Gene: _____ Exon: _____ Variant: _____
Reference Sequence: _NM_____
Gene: _____ Exon: _____ Variant: _____
Reference Sequence: _NM_____
*(HGVS nomenclature or indicate if other)*

Proband Name: _____ DOB: _____
Relationship to Patient: _____ MSH Report# : _____
**If proband testing was performed elsewhere, please attach a copy of the original result (ALL pages) and send positive control sample if available*

| Gene Panel Name | Test Code | Details |
|---|---|---|
| **POLYCYSTIC KIDNEY DISEASE (PKD)** | | |
| ☐ PKD Full Analysis | FPKD1 | Reflex order: 1) *PKD1* sequencing 2) *PKD2/ PKHD1* sequencing and *PKD1/PKD2/PKHD1* MLPA |
| ☐ Autosomal dominant PKD Analysis | DPKD1 | Reflex order: 1) *PKD1* sequencing 2) *PKD2* sequencing and *PKD1/PKD2* MLPA |
| ☐ Autosomal recessive PKD Analysis | RPKD1 | Reflex order: 1) *PKHD1* sequencing 2) *PKHD1* MLPA |
| ☐ *PKD1* Sequencing only | MPK1S | *PKD1* |
| ☐ *PKD2* Sequencing only | MPK2S | *PKD2* |
| ☐ *PKHD1* Sequencing only | MPKHS | *PKHD1* |
| ☐ *PKD1* Deletion/Duplication only | MPK1M | *PKD1* |
| ☐ *PKD2* Deletion/Duplication only | MPK2M | *PKD2* |
| ☐ *PKHD1* Deletion/Duplication only | MPKHM | *PKHD1* |
| **SARCOMA TUMOUR TESTING** | | |
| ☐ Sarcoma Fusion by NGS | MSNGR | List suspected Sarcoma Type &/or Fusion partner here or on page 1: |
| ☐ Sarcoma Pharmacogenomic Screening by NGS | MSNGD | |
| **MOLECULAR HEMATOPATHOLOGY TESTING** | | |
| ☐ Factor V Leiden & Factor II Prothrombin | MCOAG | *F5* c.1601G>A and *F2* c.*97G>A |
| ☐ Hemochromatosis Genotype | HFE | *HFE* c.845G>A and c.187C>G |
| **TUMOUR TESTING** | | |
| ☐ Expanded RAS NGS Panel | MRAST | *NRAS, KRAS, BRAF* |
| ☐ Microsatellite Instability (MSI) Testing | MMSI | |
| ☐ GIST (Gastrointestinal Stromal Tumour) Melanoma Panel | MGIST | *PDGFRA, KIT, NRAS, KRAS, BRAF* |
| ☐ Immunohistochemistry | IHC1 | MLH1, MSH2, MSH6, PMS2 |
| ☐ Somatic *BRCA1* and *BRCA2* Panel | MBRST | Please specify tumour type here or on page 1: ☐ Ovarian ☐ Fallopian Tube ☐ Other primary peritoneal cancer |
| ☐ Somatic *MLH1* Promoter Methylation | MPMET | *MLH1* |
| ☐ *BRAF* | MBRAF | Exon 15 including V600E |

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**Completion of Billing Form is NOT required for patients with an Ontario Health Card Number and meet MOH criteria for testing.**

## BILLING FORM

**At your direction, we will bill the hospital or referring physician for the services we render.**

- Invoices will be sent upon completion of each test/service
- Invoices are itemized and include the date of service, patient name, test name and charge.
- Contact the Mount Sinai Pathology and Laboratory Medicine Administration at 416-586-4800 x 5436 for billing inquiries.

**How to complete the Billing Form:**

- Referring physician or Genetic Counsellor completes the appropriate section below to specify billing method.
- Send requisition and completed "Billing Form" with specimen.

### Section 1: Healthcare Provider Billing Information:

**Billing Address of hospital, referring laboratory, clinic, referring physician, or medical group:**
Full name (Surname, First name) of person to be billed (and CPSO# if applicable):

_____

Address: _____

City: _____ Prov: _____

Postal Code: _____ Contact Phone #: _____

### Section 2: Patient Financial Responsibility Form (For patients within Ontario without OHIP coverage) Payment Information (check off as appropriate):

| | | | | | |
|---|---|---|---|---|---|
| ☐ | Out of Province / Country | ☐ | IFHP / Refugee Program | ☐ | Community Health Centre |
| ☐ | UHIP | ☐ | Uninsured / Self Pay | ☐ | Military / RCMP / Federal |

Dear Patient,
Your care is our first concern.
**Please note that many insurance providers do not cover Genetic testing. It is advisable to include a preauthorization letter from your provider.**
**My Financial Responsibility:**
I agree to pay for all hospitalization charges not covered by any other agency (OHIP, DVA, IVA, WSIB, Refugee Program) and any additional costs for which I am not insured or which are not entirely covered by my private insurance plan. In addition, I will pay for any co-payment charge incurred while awaiting placement in a nursing home, chronic or long term care facility.
I agree to permit Mount Sinai Hospital to release my health information to my private insurer for the sole purpose of receiving payment for services provided.

Patient Signature: X_____ Date:_____

**Patient/Guarantor: My signature below indicates that I have read and understand all of the above clauses.**

Patient Name _____

Signature _____

Date _____

**Witness:**
Print Name _____

Signature _____

Date _____

**Credit Card Information:** **PLEASE PRINT CLEARLY**

I authorize Mount Sinai Hospital to charge my credit card for costs not covered by Insurance or Other Agencies:

Credit Card Number: _____

Expiry Date ___ /___

Verification number (back of card) _____

Name of Cardholder _____

Signature of Cardholder _____

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