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 NM_007294.4(*BRCA1*):c.68_69del (p.Glu23fs), BRCA1 (185delAG or 187delAG) NM_007294.3(*BRCA1*):c.5266dup (p.Gln1756Profs), BRCA1 (5382insC or 5385insC) NM_000059.4(*BRCA2*):c.5946del (p.Ser1982fs), BRCA2 (6174delT) NM_007194.4(*CHEK2*):c.1283C>T (p.Ser428Phe) NM_013372.7 *GREM1* 40 kb dup NM_000251.2(*MSH2*):c.1906G>C (p.Ala636Pro), NM_000179.2 (*MSH6*):c.3984_3987dup (p.Leu1330Valfs) 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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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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