SickKids®
THE HOSPITAL FOR SICK CHILDREN

Paediatric Laboratory Medicine

MOLECULAR HAEMATOPATHOLOGY LABORATORY

555 University Avenue
Room 3603, Atrium
Toronto, ON, M5G 1X8, Canada

Tel: 416-813-7200
Fax: 416-813-5431

Patient Name:
Date of Birth (DD/MM/YYYY):
Sex Assigned at Birth: ☐Male ☐Female ☐Unassigned
Legal Sex (if different): ☐Male ☐Female ☐Non-binary/U/X
Gender Identity: ☐Male ☐Female ☐Non-binary/U/X
Parent's Name:
Address:

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

MOLECULAR HAEMATOPATHOLOGY

Referred-in Requisition

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

SPECIMEN	DELIVERY OF SPECIMENS
☐ Blood in EDTA (Lavender top tube) at room temperature (minimum 2 mL) ☐ Bone Marrow Aspirate in EDTA (Lavender Top Tube) at room temperature (minimum 2mL)	Monday to Friday between 8:30 AM to 5:00 PM **Address:** The Hospital for Sick Children Rapid Response Laboratory 170 Elizabeth Street, Room 3642 Toronto, ON, M5G 2G3, Canada

DATE (DD/MM/YYYY)	TIME (HH:MM)	COLLECTED BY

CLINICAL INFORMATION

For questions or inquiries, please contact us at cmd.laboratory@sickkids.ca

TESTS (Select all that apply)

New Leukemia Tests
☐ JAK2
☐ FLT3-ITD
☐ BCR-ABL1, t(9;22) Qualitative Testing (p190 & p210)
☐ PML-RARA, t(15;17) Qualitative Testing
☐ TPMT/NUDT15 Genotyping

Coagulation Panel
☐ Prothrombin (FII) Genotyping
☐ Factor V Leiden (F5) Genotyping
☐ Methylenetetrahydrofolate Reductase (MTHFR) Genotyping

NEXT GENERATION SEQUENCING Testing

☐ **Illumina TruSight RNA Pan-Cancer Panel**
Panel: 1385 Oncology genes.
Please consult the DPLM Catalogue Test webpage for complete gene list.
RNA-based assay
TruSight RNA Pan-Cancer Target Genes

RESPONSIBLE / REFERRING PHYSICIAN

Name (print) _____

Address _____

_____

Phone _____ Fax _____

Signature _____

COPY OF REPORT TO

Name (print) _____

Address _____

_____

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Legal Sex (if different): ☐ *Male* ☐ *Female* ☐ *Non-binary/U/X*
Gender Identity: ☐ *Male* ☐ *Female* ☐ *Non-binary/U/X*
Parent's Name:
Address:

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BILLING FORM

How to complete the Billing Form: *(Completion of Billing Form NOT required for patients with an Ontario Health Card Number.)*
- **Referring Physician completes the appropriate section below to specify billing method.**
- **Send requisition and completed "Billing Form" with specimen.**

Option 1: Complete to have the Healthcare Provider billed:	**Option 2: Interm Federal Health Program (IFHP)**

Your Referring Laboratory's Reference #: _____
 	
 Billing address of hospital, referring laboratory:
  Name: _____ Address: _____
 _____
  City: _____ Prov/State: _____
  Postal/Zip Code: _____ Country: _____
 	
  Contact Name: _____
  Contact Telephone #: _____
	Submit a copy of the Interim Federal Health Certificate (Refugee Protection Claimant Document) with the photo and UCI# visible for coverage to be confirmed.
	
	 UCI# _____
	
	 ICD code *(lab use only)*: _____

Option 3: 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.*
- ***In this case, the patient/guardian is solely responsible for the charges.***

Relation to patient (check one): ☐ Patient   ☐ Guardian/Parent

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

Name as it appears on credit card: _____

Credit card # : _____

Expiry date on credit card: _____

CVC#- found on back of card (Required): _____

Mailing Address of Patient/Guardian (if different from requisition):	**Additional Contact Information**
Name: _____ Address: _____ Apt. #: _____ City: _____ Prov/State: _____ Postal/Zip Code: _____ Country: _____	Patient's phone # with area code: _____ *- or -* Guardian's phone # with area code: