Genetics Diagnostic Laboratory
Hereditary Cancer Requisition

Blood Work Instructions For Non-CHEO Patients:
Bring requisition to local community lab for blood collection

Sample to be shipped to:
Genetics Diagnostics Laboratory
401 Smyth Road, Rm W3401
Ottawa, ON, K1H 8L1
Tel: (613) 738-3230
Fax: (613) 738-4814
Website: www.cheo.on.ca/GDL

Patient Name: _____
Last First Initial

Health Card Number: _____

DOB (yy/mm/dd): _____

Address: _____

Telephone: _____

Legal Sex: ☐ Male ☐ Female ☐ Unknown

Optional - Sex assigned at birth: ☐ Male ☐ Female ☐ Unknown ☐ Uncertain ☐ Not recorded

Patient Consent to share results (optional):

Sharing results for family testing: By checking the box below, the patient authorizes CHEO to use their results to guide testing or interpretation for relatives within CHEO's Genetic Diagnostic Lab. Results are used only to inform family member testing decisions. Consent can be changed at any time by contacting the lab.

☐ Patient consents to sharing results with family members

Priority of Testing

☐ Routine

☐ **Expedited**: Clinical management contingent upon STAT results

Sample Type (for prenatal/cord blood: separate MCC requisition required)

☐ Blood 2×6 mL EDTA
☐ Blood 3 mL EDTA
☐ DNA _____ µg
source: _____

☐ Blood 2×3 mL EDTA
☐ Cord blood 3 mL EDTA
☐ Cultured cells
source: _____

For Lab Use Only

Collection Date: _____

Collection Centre: _____

Collected By: _____

Billing (Non-OHIP / Institutional Only - *Attach Ministry of Health or IFHP approval documentation)

☐ Ministry of Health Approved (e.g. RAMQ)*
☐ Ministry of Health Pending Approval
☐ IFHP Approved*
☐ Non-insured (i.e. self-pay)

☐ Institutional Billing (complete details below)
Institution Name: _____
City: _____ **Province:** _____ **Postal Code:** _____
Tel: _____ **Fax:** _____

Authorizing Health Care Provider(s) (Genetics Clinics, affiliated sites, or mainstreamed providers from The Ottawa Hospital only)

Provider Name: _____
Registration #: _____
Address: _____
Telephone: _____ **Fax:** _____

COPY TO Name: _____
Registration #: _____
Address: _____
Telephone: _____ **Fax:** _____

Clinical Indication (required–testing will not proceed unless completed)

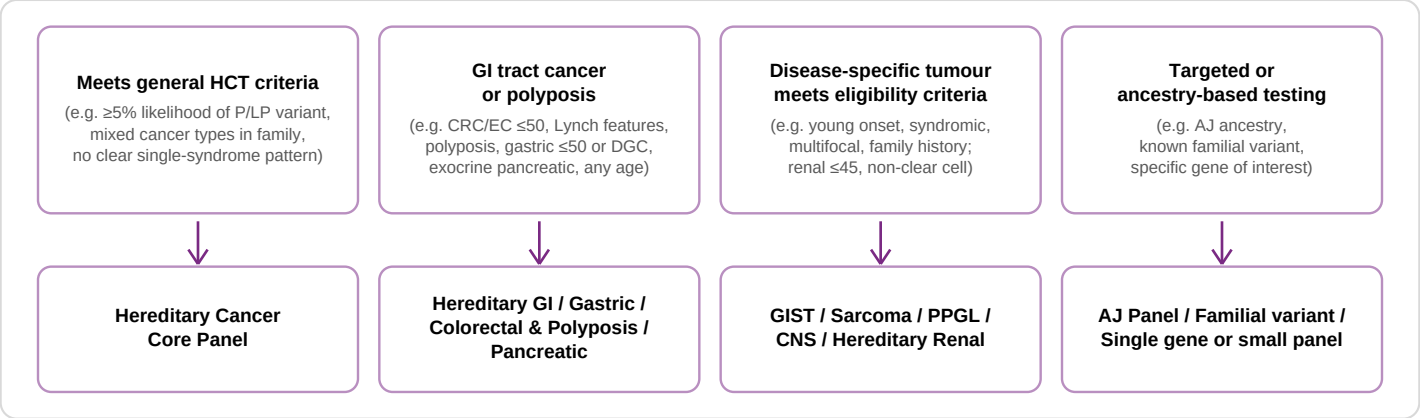
☐ Breast cancer ≤ 50 yrs, TNBC, male, bilateral, or ≥2 primaries
☐ Epithelial ovarian, fallopian tube, or peritoneal cancer
☐ Pancreatic or biliary tract cancer
☐ Genetic specialist discretion
☐ ≥5% mutation likelihood (family history, ancestry, or risk model)
☐ Familial variant testing (attach family report) Specify family relationship: _____
☐ Prostate cancer ≤ 50 yrs, metastatic, or high-risk locally advanced
☐ Colorectal or endometrial cancer ≤ 50 yrs (refer Genetics if dMMR)
☐ Gastric or GEJ adenocarcinoma ≤ 50 yrs
☐ Other (e.g.: systemic therapy, surgical decision making): _____

Privacy statement: By ordering this test, I attest that my patient/patient's guardian has obtained express consent or I have obtained express consent from the family member for CHEO to use the family member's report for the purpose of genetic testing and evaluation.

Test/Panel Requested

☐ **Hereditary Cancer Core** ☐ **Hereditary Breast/Ovarian/Prostate Cancer** ☐ **Hereditary GI**
☐ **Hereditary Renal** ☐ **Colorectal and Polyposis** ☐ **Gastric Cancer** ☐ **Pancreatic Cancer**
☐ **Ashkenazi Jewish Panel** ☐ **GIST** ☐ **Sarcoma** ☐ **PPGL**
☐ **CNS** ☐ **Familial variant testing** gene(s) and variant(s): _____ ☐ **DNA Storage (2-year retention)**
☐ **Single gene testing/small gene panel (specify– see cheo.on.ca/GDL for details):** _____

Hereditary Cancer Panels - Genetic Testing Utilization Considerations



HCT - hereditary cancer testing. **P/LP** - pathogenic/likely pathogenic. **CRC** - colorectal cancer. **EC** - endometrial cancer. **GI** - gastrointestinal. **DGC** - diffuse gastric cancer. **AJ** - Ashkenazi Jewish. **GIST** - gastrointestinal stromal tumour. **PPGL** - pheochromocytoma/paraganglioma**. CNS** - central nervous system.

Colorectal or endometrial cancer ≤50 yrs with deficient mismatch repair (dMMR) on tumour testing should be referred to Genetics. Cases with strong polyposis features, multiple primaries, or pediatric-onset cancer may warrant referral to Genetics for syndrome-specific assessment rather than a panel.

Gene content for the Hereditary Cancer Genetic Testing Panels

Panel	# Genes	Genes Included
Hereditary Cancer Core	40	APC, ATM, AXIN2, BAP1, BARD1, BMPR1A, BRCA1, BRCA2, BRIP1, CDH1, CDK4, CDKN2A, CHEK2, CTNNA1, EPCAM, GALNT12, GREM1, HOXB13, MLH1, MLH3, MSH2, MSH3, MSH6, MUTYH, NTHL1, PALB2, PMS2, POLD1, POLE, PTEN, RAD51C, RAD51D, RNF43, RPS20, SDHB, SDHD, SMAD4, STK11, TP53
Hereditary Breast/Ovarian/Prostate Cancer	19	ATM, BARD1, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, EPCAM, HOXB13, MLH1, MSH2, MSH6, PALB2, PMS2, PTEN, RAD51C, RAD51D, STK11, TP53
Hereditary GI Cancer (Lynch, Colorectal, Endometrial, Gastric, Pancreas, Polyposis)	34	APC, ATM, AXIN2, BMPR1A, BRCA1, BRCA2, CDH1, CDK4, 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
Gastric Cancer	18	APC, ATM, BMPR1A, BRCA1, BRCA2, CDH1, CTNNA1, EPCAM, MLH1, MSH2, MSH6, PALB2, PMS2, SDHB, SDHD, SMAD4, STK11, TP53
Colorectal and Polyposis	23	APC, AXIN2, BMPR1A, EPCAM, GALNT12, GREM1, MLH1, MLH3, MSH2, MSH3, MSH6, MUTYH, NTHL1, PMS2, POLD1, POLE, PTEN, RNF43, RPS20, SMAD4, STK11, TP53
Pancreatic Cancer	14	APC, ATM, BRCA1, BRCA2, CDK4, CDKN2A, EPCAM, MLH1, MSH2, MSH6, PALB2, PMS2, STK11, TP53
GIST	8	KIT, NF1, PDGFRA, SDHA, SDHAF2, SDHB, SDHC, SDHD
Sarcoma	14	APC, ATM, BRCA1, BRCA2, CHEK2, DICER1, EPCAM, MLH1, MSH2, MSH6, NF1, PMS2, RB1, TP53
PPGL	12	FH, MAX, MEN1, NF1, RET, SDHA, SDHAF2, SDHB, SDHC, SDHD, TMEM127, VHL
CNS	20	APC, EPCAM, LZTR1, MLH1, MSH2, MSH6, NF1, NF2, PMS2, POLE, POT1, PTCH1, PTEN, SMARCB1, SMARCE1, SUFU, TP53, TSC1, TSC2, VHL
Hereditary Renal	15	BAP1, FH, FLCN, MET, MITF, PTEN, SDHA, SDHAF2, SDHB, SDHC, SDHD, TP53, TSC1, TSC2, VHL
Ashkenazi Jewish Panel	7	APC, BRCA1, BRCA2, CHEK2, GREM1, MSH2, MSH6