



COLORECTAL CANCER TEST REQUISITION

Fields must be completed LEGIBLY (patient demographics may be addressographed instead).

Patient Name (last, first) _____ PHN _____ Expiry (mm / yy) _____

Date of Birth (D/M/Y) _____ Sex M F BCCA patient Yes No BCCA No. _____

Requesting Physician name _____ MSC _____

Address _____

Phone number _____ Fax number _____

Report copy to (all information is necessary to receive a report)

Name: _____ MSC _____ Address _____

Name: _____ MSC _____ Address _____

Testing required

Lynch syndrome dMMR + MSI test on colorectal cancer diagnosed at or before 50 years of age

5 FU therapy dMMR test on colorectal cancer age > 50 yr. This requires the approval of BCCA – VCC Medical Director _____

Originating Hospital _____ Specimen # _____ Procedure date _____

Originating Hospital Fax # _____ Tissue type _____

Tumour block # _____ Normal tissue block # _____

Normal tissue not available

Instructions for Originating Hospital

Please send one block of tumour and one block of normal tissue. **Please note that testing will not be performed if normal tissue is not sent.** If normal tissue is not available call the lab at (604) 877-6000 # 2084. Indicate respective block numbers above (note that if the block numbers are not specified, the blocks will be returned untested).

Also include this requisition and a copy of the pathology report.

Send all to:

Pathology Office - Room 3225
BC Cancer Agency
600 West 10th Avenue
Vancouver, BC V5Z 4E6

For Cancer Genetics Lab use only

Date Received _____ % tumour _____ Initials _____

Lab Number (par-N/PB) _____

Lab Number (par- tumour) _____