Provincial Health Services Authority
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BC CANCER
Provincial Health Services Authority

LAB USE ONLY

BIOMARKER REQUEST FORM

ALL FIELDS MUST BE COMPLETED LEGIBLY – ADDRESSOGRAPH LABEL IS ACCEPTABLE

Patient Name (Last, First):			**PHN:**
Date of Birth (dd/mmm/yy):	**Sex: M❑ F❑ U❑ X❑**	**BC Cancer Patient: Y❑ N ❑**	**Cerner MRN:**
Requesting Physician Name (Last, First):			**MSP:**
Phone #:		**Fax #:**	
Copy To Physician Name (Last, First):		**Phone #:**	**MSP:**
Copy To Physician Name (Last, First):		**Phone #:**	**MSP:**
Hospital:			
Pathology Case #:		**Block:**	

When requisition is complete, fax to the hospital lab that holds the tissue.

SAMPLE INFORMATION:			
Fixative:	❑ Neutral Buffered Formalin	❑ Other (specify):	
Ischaemic Time:	❑ < 1 hr	❑ > 1 hr	❑ Unknown
Fixation Time:	❑ < 6 hrs	❑ 6-72 hrs	❑ > 72 hrs

STANDARD OF CARE BIOMARKERS:		
BREAST:	❑ DCIS (ER Only)	
	❑ Invasive Carcinoma (ER, PR, HER2)	
	❑ HER2 Only	
	❑ PDL1 22C3 Triple Negative Breast Cancer	
	❑ Ki67* (ER+ HER2- Breast Cancer) **for BC Cancer Oncologists use only*	
Gastro-Intestinal (GI):	❑ HER2: GE Junction / Stomach / Esophagus	
	❑ MMR	❑ PDL1
GYNE:	❑ p53	
	❑ MMR	
	❑ ER	
Other:	PDL1 22C3 Specify Site: ◯ Cervix ◯ Lung ◯ Head & Neck	
	❑ HER2 Specify Site:	
	❑ MMR Specify Site:	

Originating Hospital: Please send one representative tumour block, this requisition, and a copy of the pathology report to:
BC Cancer Pathology Office - Room 3225 600 West 10th Avenue Vancouver, BC V5Z 4E6

REQUESTING PHYSICIAN SIGNATURE:_____ **DATE SIGNED:**_____