Provincial Health Services Authority
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BC Cancer Agency
CARE & RESEARCH
An agency of the Provincial Health Services Authority

Addressograph only

CANCER GENETICS REQUISITION VHL INDEX TESTING

Cancer Genetics Lab Room # 3305
600 West 10th Avenue, Vancouver BC V5Z 4E6
Phone: (604) 877 6000 Ext. 672094

All fields must be completed LEGIBLY (patient demographics may be addressographed**).**

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

Date of Birth(dd/mmm/yyyy) _____ **Sex M F** **BCCA №** _____

Requesting Physician _____ **MSC** _____ **Signature** _____

Physician Address _____ **Phone №** _____

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

Name: _____ MSC _____ Address _____

Name: _____ MSC _____ Address _____

Specimen Type: ☐ Peripheral Blood

Specimen Collection Date: (dd/mm/yy) _____ **Time**: _____ **(fill out at collection)**

Collect 2 x 4mL peripheral blood in EDTA tubes (lavender top), ship at ambient temperature. Do NOT spin or freeze. Samples must be shipped to the lab (address above) as soon as possible and received within 48 hours after collection. Avoid arrival on Fridays, weekends and public holidays.

Important Information: Genetic Testing for von Hippel Lindau Syndrome

The BCCA Cancer Genetics Lab sequences all 3 exons of the VHL gene. This method can detect point mutations, and small insertions and deletions, which account for approximately 70% of mutations in the VHL gene. Further genetic testing to detect large deletions or duplications in the VHL gene, and/or for additional genes may be available to the patient through referral to the BCCA Hereditary Cancer Program. Information is available at http://www.screeningbc.ca/Hereditary/ForHealthProfessionals/vonHippelLindauSyndrome.htm

INDICATION FOR INDEX VHL TESTING – THIS SECTION MUST BE COMPLETED

- ☐ **Simplex case** (an individual with no known family history of VHL) presenting with two or more characteristic lesions (e.g., two or more hemangioblastomas of the retina or brain or a single hemangioblastoma in association with a visceral manifestation such as kidney or pancreatic cysts; renal cell carcinoma; adrenal or extra-adrenal pheochromocytomas, and, less commonly, endolymphatic sac tumors, papillary cystadenomas of the epididymis or broad ligament, or neuroendocrine tumors of the pancreas).
- ☐ **Individual with positive family history of VHL syndrome** in whom one or more of the following disease manifestations is present: retinal angioma, spinal or cerebellar hemangioblastoma, pheochromocytoma, multiple pancreatic cysts, epididymal or broad ligament cystadenomas, multiple renal cysts, or renal cell carcinoma before age 60 years.
- ☐ **Isolated pheochromocytoma.**
- ☐ **Individual with clear cell renal carcinoma with a first or second degree relative with clear cell renal carcinoma.**

All Carrier testing and non-specialized physician requests should be referred to the Hereditary Cancer Program 604-877-6000, local 672198. Information is available at http://www.screeningbc.ca/Hereditary/default.htm

In submitting this specimen, the requesting physician warrants that informed consent to perform the requested analysis was obtained. If the requested analysis is to be performed on a minor the requesting physician warrants that results will inform immediate clinical management of this patient.

_____ _____

signature of Requesting MD Date (dd/mmm/yy)

For Cancer Genetics Lab use only

Lab Number B___-_____ Date Received _____ Initial_____

Sample received :_____tubes of _____mL EDTA(PB),___tubes of _____mL Na Hep