

## 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 <input type="checkbox"/> F <input type="checkbox"/> U <input type="checkbox"/> X <input type="checkbox"/>	BC Cancer Patient: Y <input type="checkbox"/> N <input type="checkbox"/>	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:	<input type="checkbox"/> Neutral Buffered Formalin	<input type="checkbox"/> Other (specify):	
Ischaemic Time:	<input type="checkbox"/> < 1 hr	<input type="checkbox"/> > 1 hr	<input type="checkbox"/> Unknown
Fixation Time:	<input type="checkbox"/> < 6 hrs	<input type="checkbox"/> 6-72 hrs	<input type="checkbox"/> > 72 hrs

**STANDARD OF CARE BIOMARKERS:**

BREAST:	<input type="checkbox"/> DCIS (ER Only)		
	<input type="checkbox"/> Invasive Carcinoma (ER, PR, HER2)		
	<input type="checkbox"/> HER2 Only		
	<input type="checkbox"/> PDL1 22C3 Triple Negative Breast Cancer		
	<input type="checkbox"/> Ki67* (ER+ HER2- Breast Cancer) *for BC Cancer Oncologists use only		
Gastro- Intestinal (GI):	<input type="checkbox"/> HER2: GE Junction / Stomach / Esophagus		
	<input type="checkbox"/> MMR	<input type="checkbox"/> PDL1	<input type="checkbox"/> CLAUDIN 18.2
	<input type="checkbox"/> p53	HER2: GYNE CRITERIA (TRASTUZUMAB) HER2: GASTRIC CRITERIA (TRASTUZUMAB DERUXTECAN)	
<input type="checkbox"/> MMR			
<input type="checkbox"/> ER			
Other:	PDL1 22C3 Specify Site: <input type="radio"/> Cervix <input type="radio"/> Lung <input type="radio"/> Head & Neck		
	<input type="checkbox"/> HER2 Specify Site:		
	<input type="checkbox"/> 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:** \_\_\_\_\_

The personal information collected on this form is collected under the authority of the Personal Information Protection Act. The personal information is used to provide medical services requested on this requisition. The information collected is used for quality assurance management and disclosed to healthcare practitioners involved in providing care or when required by law. Personal information is protected from unauthorized use and disclosure in accordance with the Personal Information Protection Act and when applicable the Freedom of Information and Protection of Privacy Act and may be used and disclosed only as provided by those Acts.