Oncotype Dx Requisition

Calgary Lab Phone 403.943.5642 **or** 403.943.4783
Fax 403.291.2931

Edmonton Zone IHC Lab Phone 780.613.7154 Fax 780.429.2819

Scanning Label or Accession # *(lab only)*

Patient

PHN Expiry: ________	Date of Birth *(dd-Mon-yyyy)*		
Legal Last Name	Legal First Name	Middle Name	
Alternate Identifier	Preferred Name	☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to disclose	Phone
Address	City/Town	Prov	Postal Code

Provider(s)

Authorizing Provider Name *(last, first, middle)*			Copy to Name *(last, first, middle)*	Copy to Name *(last, first, middle)*
Address		Phone	Address	Address
CC Provider ID	CC Submitter ID	Legacy ID	Phone	Phone
Clinic Name			Clinic Name	Clinic Name

Collection	Date *(dd-Mon-yyyy)*	Time *(24 hr)*	Location	Collector ID

Requesting Oncologist to complete

Confirm Test Criteria

Node Negative/ITC/ Micromets (1-3)	Node Positive (1-3)	Surgical Accession Number
☐ ER positive ☐ HER2 negative ☐ Grade 2 or 3 ☐ Size greater than 1 cm	☐ ER positive ☐ HER2 negative ☐ Post menopausal	Accession Number ____________________ Best Tumor Block *(if known)* ________________

All Criteria must be met and accession number completed before testing can proceed

Comments

IMPORTANT - Medical Oncologists approved to order Oncotype Dx will no longer require pre-approval but will fax the completed Oncotype Dx Requisition to the lab that completed the original biomarker testing.

Oncologist Name *(last, first name)*	Oncologist Signature	Date *(dd-Mon-yyyy)*