

**OUT OF PROVINCE / OUT OF COUNTRY LABORATORY AND GENETIC TEST FUNDING APPLICATION**

<b>Internal use only:</b>		Fully complete this form to request prior approval of payment on behalf of your patient for medically necessary laboratory or genetic testing services not provided in BC.			
<b>APPLICATION #:</b>		<p><b>Application, signed patient Consent for Release of Information</b>, and any additional required documents should be faxed to <b>604-699-9718</b> or mailed to: Provincial Laboratory Medicine Services, Out of Province/Out of Country Program, 300-1867 West Broadway, Vancouver, BC, V6J 4W1.</p> <p>The OOP/OOC program agrees to fund services specifically as stated on the approval letter. Patient PHN <b>MUST</b> be active on the date of service to be covered by the program.</p>			
<b>Date Received:</b>					
<b>PATIENT (Beneficiary) INFORMATION</b>					
LAST NAME		FIRST NAME		MIDDLE NAME	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> X <input type="checkbox"/> Unknown
BC PERSONAL HEALTH NUMBER		DATE OF BIRTH (YYYY-MMM-DD)		POSTAL CODE	
<b>TESTING ON:</b> <input type="checkbox"/> Beneficiary	<input type="checkbox"/> Fetus (current pregnancy): Gestational age:			<input type="checkbox"/> Deceased previous pregnancy: Date of Demise:	
<input type="checkbox"/> Deceased relative of beneficiary Relationship to Beneficiary:		Name (and PHN if known):		Date of Birth:	Date of Death:
<b>REFERRING PRACTITIONER INFORMATION</b>					
LAST NAME		FIRST NAME		SPECIALTY	MSP NUMBER
MAILING ADDRESS			CITY	PROVINCE	POSTAL CODE
EMAIL ADDRESS			PHONE NUMBER		FAX NUMBER
<b>REQUEST INFORMATION (Required for all tests)</b>					
1	<b>Rapid application review required:</b> <input type="checkbox"/> Acutely ill / deteriorating inpatient <input type="checkbox"/> Current pregnancy: EDD:				
2	<b>Brief Clinical Diagnosis / Relevant Information:</b> (Additional information/documentation/consult note may be required)				
3	Test Requested (one form per vendor lab):				Test Code (if known):
4	Preferred OOP Approved Lab:	New Lab Name: New Lab Address:			Reason for new Laboratory:
5	Preferred Test Method: <input type="checkbox"/> None / default to best method	Other (E.g., Sanger sequencing, MLPA, Mass Spec): Specify:			
6	Completed prerequisite in-province tests: <input type="checkbox"/> N/A / None that I am aware of	Test(s) and Result(s): (E.g. CMA, FragX, SCA, Serum Tryptase, etc.)			
7	Any pre-requisite or relevant laboratory or genetic tests currently underway for the patient: <input type="checkbox"/> N/A				
	Test(s):			Anticipated completion date:	

8	Has funding for this test been requested previously for this patient? <input type="checkbox"/> No <input type="checkbox"/> Yes: Application Number:		
	<input type="checkbox"/> Monitoring	<input type="checkbox"/> Change request	Reason:
	<input type="checkbox"/> Expired decision letter	<input type="checkbox"/> Original Request Denied	
<input type="checkbox"/> Repeat or Additional testing required based on new information or patient's presentation has changed			
<input type="checkbox"/> Previous test not completely explanatory for the patient's condition AND more than 5 years have passed since previous test			
9	If the result is <b>informative</b> , how will the information <b>significantly</b> change patient management? Consult note may be required.	<b>Specific details required:</b>	
10	If the result is non-informative, how will this impact patient management? <input type="checkbox"/> Patient management will not / is unlikely to change <input type="checkbox"/> No further investigations	<input type="checkbox"/> Other (Consult note may be required):	
11	What are the implications for patient management if testing is not performed? <input type="checkbox"/> Patient management will not / is unlikely to change	<input type="checkbox"/> Other (Consult note may be required):	
12	Name(s) / specialty(s) of <b>other</b> BC or Canadian specialist(s) consulted for this medical condition (if applicable):		
13	<b>NON- GENETIC TESTS ONLY:</b> Has this request been discussed with a BC laboratory physician? <input type="checkbox"/> No <input type="checkbox"/> Yes		
	If yes, name of the BC laboratory physician(s):		

**Applications for non-genetics tests proceed to physician signature and date below at bottom of page.**

GENETICS / GENOMICS Testing: complete this section			
14	Relevant Family History (Pedigree may be required):	Consanguinity? <input type="checkbox"/> No <input type="checkbox"/> Yes (detail):	
15	Has <b>this patient</b> or any biological family member had genetic testing: <input type="checkbox"/> No	<input type="checkbox"/> Yes: Biological Relationship:	
	IF tested through OOP: Name or PHN or Application #:	Test:	Lab: Test Result Date:
	Result: [gene nomenclature, zygosity (homo/hetero/hemi), AD AR XL, pathogenicity classification]:		
16	Specimen type (for this patient's test): <input type="checkbox"/> Blood	<input type="checkbox"/> Buccal <input type="checkbox"/> Saliva <input type="checkbox"/> Urine	<input type="checkbox"/> Dried Blood Spot <input type="checkbox"/> Direct CVS / Amniotic Fluid <input type="checkbox"/> Cell culture / Extracted DNA
		<input type="checkbox"/> Tissue (specify):	
17	What is the impact of this testing <b>for at-risk relatives</b> ? <input type="checkbox"/> Preventive management <input type="checkbox"/> Predictive	<input type="checkbox"/> Screening recommendations / risk reduction strategies (specify):	
18	<b>Primary</b> purpose for testing (select one): <input type="checkbox"/> Confirm / Clarify diagnosis <input type="checkbox"/> Identify potential treatment options available <input type="checkbox"/> Recurrence risk for this patient <input type="checkbox"/> Recurrence risk for other family members	<input type="checkbox"/> Other:	
19	Genetic Counselor:	Email:	Contact Phone Number:

By signing, I confirm that the above information thoroughly and accurately presents this patient's medical need for testing.

Referring Practitioner Signature:	Date (YYYY-MM-DD)
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