Provincial Health Services Authority
Province-wide solutions. Better health.

Provincial Laboratory Medicine Services

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

Internal use only: APPLICATION #: **Date Received:**	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. **A signed patient Consent for Release of Information** and any additional required documents should be faxed to **604-730-1928** or mailed to: Provincial Laboratory Medicine Services, Out of Province/Out of Country Program, 300-1867 West Broadway, Vancouver, BC, V6J 4W1. **PHSA only:** Completed application with consent and any additional required documents can be submitted by email to ooc@phsa.ca . The OOP/OOC program agrees to fund services specifically as stated on the approval letter.

PATIENT (Beneficiary) INFORMATION

LAST NAME	FIRST NAME	MIDDLE NAME	GENDER ☐ Male ☐ Female ☐ Unknown
BC PERSONAL HEALTH NUMBER	DATE OF BIRTH (YYYY-MMM-DD)	POSTAL CODE	

TESTING ON: ☐ Beneficiary	☐ Fetus (current pregnancy): Gestational age:	☐ Deceased previous pregnancy: Date of Demise:

☐ Deceased relative of beneficiary Relationship to Beneficiary:	Name (and PHN if known):	Date of Birth:	Date of Death:

REFERRING PRACTITIONER INFORMATION

LAST NAME	FIRST NAME	SPECIALTY	MSP NUMBER
MAILING ADDRESS	CITY	PROVINCE	POSTAL CODE
EMAIL ADDRESS	PHONE NUMBER	ALTERNATE PHONE NUMBER	FAX NUMBER

REQUEST INFORMATION (Required for all tests)

1	☐ **Rapid application review required** ☐ Acutely ill / deteriorating inpatient ☐ Current pregnancy: EDD:	☐ Additional funding needed for rapid results for treatment decisions: Specify:	☐ Faxed Decision Letter: Reason:
2	**Brief Clinical Diagnosis / Relevant Information:** (Additional information/documentation/consult note may be required)		
3	Test Requested:(one form per vendor lab)		Test Code (if known):
4	Preferred Testing Lab: OOP Approved Vendor Lab:	Other Lab name: Other Lab Address:	Reason for other / new Laboratory:
5	Preferred Test Method: ☐None / default to best method	Other (E.g., MLPA, Sanger sequencing, Mass Spec): Specify:	
6	Completed prerequisite in-province tests: ☐ N/A / None that I am aware of	Tests and Results:	
7	Any specialized laboratory or genetic tests currently underway for the patient: ☐ N/A		
	Test(s):	Anticipated completion date:	

8	Has funding for this test been requested previously for this patient? ☐ No ☐ Yes: Reason for repeat request (below):			
	☐ Monitoring ☐ Expired decision letter: Application #:	☐ New information / patient's clinical presentation has changed	☐ Previous test not completely explanatory for the patient's condition AND more than 5 years have passed since previous test	
	☐ Original request was denied	Reason:		
9	If the result is **informative**, how will the information **significantly** change patient management? Consult note may be required.	**Specific details required:**		
10	If the result is **non-informative**, how will this impact patient management? ☐ Patient management will not / is unlikely to change ☐ No further investigations	☐ Other (Consult note may be required):		
11	What are the implications for patient management if testing is not performed? ☐ Patient management will not / is unlikely to change	☐ Other (Consult note may be required):		
12	Name(s) / specialty(s) of **other** BC or Canadian specialist(s) consulted for this medical condition (if applicable):			
13	**NON- GENETIC TESTS ONLY:** Has this request been discussed with a BC laboratory physician? ☐ No ☐ 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? ☐ No ☐ Yes (detail):
15	Has molecular testing been done for any biological family member: No ☐	☐ Yes: Biological Relationship:		
	IF tested through OOP: Proband 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): ☐ Blood	☐ Buccal ☐ Saliva ☐ Urine	☐ Dried Blood Spot ☐ Direct CVS or Amniocytes ☐ Cell culture / Extracted DNA	☐ Tissue (specify):
17	What is the impact of this testing **for at-risk relatives**? ☐ Preventive management ☐ Predictive	☐ Screening recommendations / risk reduction strategies (specify):		
18	**Primary** purpose for testing (select one): ☐ Confirm / Clarify diagnosis ☐ Identify potential treatment options available ☐ Recurrence risk for this patient ☐ Recurrence risk for other family members	☐ 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/MMM/DD)