

Protocol: Out-of-Province Genetic Testing Coordination - PLMS funded

Division of Genome Diagnostics

This protocol outlines the process of coordinating clinical testing funded by the Provincial Laboratory Medicine Services (PLMS).

The Division of Genome Diagnostics provides 'shipping and handling' services only.

**For tests funded by sources other than PLMS, see:*

[Out-of-Province Genetic Testing Coordination - non-PLMS funded](#)

The following protocol is the responsibility of the Ordering Physician.

STEP ONE: Request Funding.

FUNDING MUST BE SECURED PRIOR TO SAMPLE COLLECTION.

1. Choose a Testing Laboratory. Resources: <http://www.ncbi.nlm.nih.gov/gtr/> and www.genetests.org.
2. Obtain from the Testing Laboratory:
 - a. Requisition;
 - b. Consent form, if applicable;
 - c. Billing form, if applicable;
 - d. Cost of the test;
 - e. Turnaround time;
 - f. Sample Requirements: confirm that 4 mL EDTA peripheral blood is sufficient.
 - i. For other sample sources (frozen or paraffin tissue, amniocentesis, CVS): Discuss with Division prior to arranging testing.
3. Apply to Provincial Laboratory Medicine Services (PLMS) for funding:
<http://www.phsa.ca/plms/forms-test-information/out-of-province-out-of-country-test-request-forms>

If PLMS Funding is Approved:

STEP TWO: Complete the Required Paperwork.

1. **Testing Laboratory Requisition** and any associated paperwork such as billing form or consent form. Ensure the form is completed in full, including Ordering Physician name and contact information.

Request "institutional billing" and state:

Bill at your institutional rate to:

Out of Province/Out of Country Program
Provincial Laboratory Medicine Services
Suite 300-1867 West Broadway
Vancouver, BC V6J 4W1 CANADA

Include the patient name, PHN, referring physician name, and report with the invoice.

2. [Request for Shipment for Out-of-Province Genetic Testing Form](#)

STEP THREE: Fax completed paperwork to the Division at 604-875-2707, in the following order:

- a. Request for Shipment for Out-of-Province Genetic Testing Form
- b. Testing laboratory requisition, billing form, and consent form, if applicable
- c. The PLMS funding approval letter

STEP FOUR: Arrange Sample Collection.

1. Complete the Genome Diagnostics Constitutional Genetics Laboratory Requisition:
http://genebc.ca/uploads/FORMS/CWGG_REQ_0000_General_Requisition_extend.pdf

Sample type: EDTA blood

- i. If > 4 mL EDTA blood required for testing, specify volume.
- ii. Test requested: Other "PLMS funded: [Test Name]"

2. Send patient for blood collection. Sample can be collected at *any* BC collection facility.



Upon sample receipt, Genome Diagnostics will:

- ship the entire blood sample and paperwork to the referral laboratory;
- send a letter to the referring physician, confirming the shipment, including date sent, to allow for tracking.

STEP FIVE: Contact the Testing Laboratory directly for result tracking and/or reporting.

Molecular Genetics Laboratory

BC Children's Hospital & BC Women's Hospital
 2J40 - 4500 Oak Street, Vancouver, BC V6H 3N1
 Phone (604) 875-2852 • Fax (604) 875-2707
 • moleculargenetics@cw.bc.ca • www.genebc.ca
 • Facility Code L1050

Request for Shipment

Out-of-Province/Out-of-Country Genetic Testing

To: Molecular Genetics Laboratory (MGL)**Fax:** 604-875-2707**Phone:** 604-875-2852

From:
Fax:
Date:
Pages:

COMPLETE FOR EACH SAMPLE & EACH REFERRAL LABORATORY

PRIORITY	SAMPLE TYPE	
<input type="checkbox"/> STAT (affects pregnancy management) EDD: _____ <small>DD/MMM/YY</small> <input type="checkbox"/> ROUTINE	<input type="checkbox"/> BLOOD <input type="checkbox"/> TISSUE ; Surgical Path #: _____ <input type="checkbox"/> DNA* ; MGL Sample ID: _____ <small>*prior approval required, as per policy</small> Quantity: _____ ug OR _____ ug/ul & _____ ul	MEDICAL GENETICS ONLY: CVS OR AMNIOCENTESIS: <input type="checkbox"/> DNA <input type="checkbox"/> Cultured <input type="checkbox"/> Uncultured* <small>*consultation required</small> SPECIAL INSTRUCTIONS: (quantity, # flasks, etc.) _____

REQUESTOR INFORMATION		PATIENT INFORMATION	
Ordering Physician Last Name	Ordering Physician First Name	Last Name	First Name
Contact Person (if differs from Ordering Physician)		Personal Health Number	Date of Birth (DD/MMM/YY)
Contact Phone Number (if differs from above)		Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> UNK	Referring Clinic ID

REFERRAL LABORATORY & TEST INFORMATION	
Referral Laboratory	Disorder or Test Requested
Shipping Address:	

CHECKLIST: <input type="checkbox"/> Provincial Laboratory Medicine Services Agreement and Consent for Out of Province testing form <input type="checkbox"/> Referral Lab paperwork <input type="checkbox"/> Provide Funding Details:	MGL USE ONLY <div style="font-size: 2em; opacity: 0.5;">SHIPMENT</div> <div style="font-size: 2em; opacity: 0.5;">LABEL</div>
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