BC's Agency for Pathology and Laboratory Medicine



OUT OF PROVINCE / OUT OF COUNTRY LABORATORY AND GENETIC TESTING SERVICES FUNDING APPLICATION

All sections of this form must be fully completed and legible.

This form is required to request prior approval for payment for insured out of province or out of country diagnostic laboratory and genetic testing services on behalf of your patient. Please complete on application per patient per test. The information provided can be released to the patient and/or their quardian upon request.

Please submit this form with a signed patient's consent (BC's Agency for Pathology and Laboratory Medicine's Agreement and Consent for Out of Province Testing).

PATIENT INFORMATION

Send completed application and signed patient's consent by fax to 604-730-1928 or by mail to Out of Province/Out of Country Program, BC's Agency for Pathology and Laboratory Medicine, 300-1867 West Broadway, Vancouver, BC, V6J 4W1.

SURNAME	FIRST NAME		INITIALS	GENDER □ Male □ Female □ Unknown			
BC PERSONAL HEALTH NUMBER	DATE OF BIRTH (YYYY-MMM-DD)		☐Outpatier ☐Inpatient, no. of days	APPLICATION IS FOR □ Outpatient □ Inpatient, and specify anticipated no. of days			
ADDRESS		CITY	PROVINCE	POSTAL CODE			
REFERRING PRACTITIONER INFORMATION							
SURNAME FIRST NAME				BER			
SPECIALTY				DRESS			
ADDRESS		CITY	PROVINCE	POSTAL CODE			
PHONE NUMBER	ALTERNATE PHON	E NUMBER	FAX NUMBER	1			
PEOUE	ET INICODMATI	ON (Required f	or all toata)				
Is this request urgent (i.e., is you results needed for treatment dec □ No □ Yes, please specify. If an explurgent. Note: You will be contact.	ur patient pregna cisions within 6-8 lanation is not pro ted by phone to s	nt and results will weeks)? ovided it will be ass support an expedie	affect manage sumed that the ent review prod	e request is not cess.			
2. Clinical Diagnosis (supporting information required, e.g. consultation note and/or medical recommendation letter(s) supporting medical necessity of the out of province/out of country laboratory or genetic testing services. Please provide a rationale if supporting information is not included.)							
3. Has this request been discussed □No □Yes, please provide the name							

Ver. May 23/18

BC's Agency for Pathology and Laboratory Medicine



4.	Name(s) and specialty(s) of other BC and Canadian specialist(s) consulted for this medical condition, if applicable.
5.	Name of laboratory test or genetic test requested. Specify condition or differential for genetic testing.
6.	Do you have a preferred test method? □No
	☐Yes, please specify testing method details.
7.	Do you have a preferred testing laboratory?
	□No □Yes, please specify the name and address of the laboratory.
	Provide rationale for your preferred laboratory (check all that applies).
	□ Previously used with success □ Other, please specify □ Optimal price
	□Superior testing method quality
8.	Has this test been previously ordered or performed for this patient? □No
	☐Yes, please specify the reason for submitting this request.
9.	Is any additional specialized laboratory or genetic testing currently underway for the patient?
9.	Is any additional specialized laboratory or genetic testing <u>currently</u> underway for the patient? □No □Yes, please list the test(s) □None that I am aware of
	□No □Yes, please list the test(s) □None that I am aware of Have you requested this test for a <i>different</i> patient before?
10	□No □Yes, please list the test(s) □None that I am aware of Have you requested this test for a <i>different</i> patient before? □No □Yes If the test result is informative, what is the impact of this testing <i>for the patient</i> ? Please select all that
10	□No □Yes, please list the test(s) □None that I am aware of Have you requested this test for a <i>different</i> patient before? □No □Yes If the test result is informative, what is the impact of this testing <i>for the patient</i> ? Please select all that apply.
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10	□No □Yes, please list the test(s) □None that I am aware of Have you requested this test for a different patient before? □No □Yes If the test result is informative, what is the impact of this testing for the patient? Please select all that apply. □Initiate new disease management □Change to more appropriate management □Cease or reduce investigation for a possible diagnosis
10	□No □Yes, please list the test(s) □None that I am aware of Have you requested this test for a <i>different</i> patient before? □No □Yes If the test result is informative, what is the impact of this testing for the patient ? Please select all that apply. □Initiate new disease management □Change to more appropriate management
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10	□No □Yes, please list the test(s) □None that I am aware of Have you requested this test for a different patient before? □No □Yes If the test result is informative, what is the impact of this testing for the patient? Please select all that apply. □Initiate new disease management □Change to more appropriate management □Cease or reduce investigation for a possible diagnosis □Alter or change in prognosis □Rule out the diagnosis
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10	No □Yes, please list the test(s) Have you requested this test for a different patient before? □No □Yes If the test result is informative, what is the impact of this testing for the patient? Please select all that apply. □Initiate new disease management □Change to more appropriate management □Cease or reduce investigation for a possible diagnosis □Alter or change in prognosis □Rule out the diagnosis □Confirm the diagnosis □Influence reproductive management □No impact
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Ver. May 23/18 2

BC's Agency for Pathology and Laboratory Medicine



12	If the test result is non-informat	ive, how will this im	pact your patient	management?			
	☐ See consultation note						
	□Other, please specify						
10	13 What are the implications for the patient if testing is not performed? Discuss patient management,						
13.	genetic counselling, etc.						
	☐ See consultation note						
	☐Other, please specify						
	Other, please specify						
14.	What is the therapeutic impact	of this testing for a	t risk relatives?				
	□ Preventive management						
	☐ Specific screening recommer						
	☐ Identify individuals at risk – lit	ttle or no change ir	n management				
	☐No individuals at risk						
	Please elaborate on the ramif	fications.					
15	Is genetic or genomic testing in	volved?					
	□No		☐Yes. Comple	te the required section below			
				•			
		NFORMATION (F	Required for ge	netic tests <u>only</u>)			
16	Is there a family history of this of		•				
	Is there a family history of this \Box No	condition?	□Yes. Include	pedigree as supporting document			
	Is there a family history of this c □No Has there been a molecular get	condition? netic diagnosis ma	☐Yes. Include de for other family	pedigree as supporting document			
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Ver. May 23/18 3