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 #:**	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. **Application, signed patient Consent for Release of Information,** and any additional required documents should be faxed to **604-699-9718** or mailed to: Provincial Laboratory Medicine Services, Out of Province/Out of Country Program, 300-1867 West Broadway, Vancouver, BC, V6J 4W1.
Date Received:	The OOP/OOC program agrees to fund services specifically as stated on the approval letter. Patient PHN **MUST** be active on the date of service to be covered by the program.

PATIENT (Beneficiary) INFORMATION

LAST NAME	FIRST NAME	MIDDLE NAME	SEX ☐ Male ☐ Female ☐ X ☐ 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	FAX NUMBER	

REQUEST INFORMATION (Required for all tests)

1	**Rapid application review required:** ☐ Acutely ill / deteriorating inpatient	☐ Current pregnancy: EDD:	
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 OOP Approved Lab:	New Lab Name: New Lab Address:	Reason for new Laboratory:
5	Preferred Test Method: ☐ None / default to best method	Other (E.g., Sanger sequencing, MLPA, Mass Spec): Specify:	
6	Completed prerequisite in-province tests: ☐ 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: ☐ N/A		
	Test(s):	Anticipated completion date:	

8	Has funding for this test been requested previously for this patient? ☐ No ☐ Yes: Application Number:		
	☐ Monitoring ☐ Expired decision letter	☐ Change request ☐ Original Request Denied	Reason:
	☐ Repeat or Additional testing required based on new information or patient's presentation has changed ☐ 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 **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 ***this patient*** or any biological family member had genetic testing: ☐ No	☐ 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): ☐ Blood	☐ Buccal ☐ Saliva ☐ Urine	☐ Dried Blood Spot ☐ Direct CVS / Amniotic Fluid ☐ 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)