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. **Completed 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. 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.
Date Received:	

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 relevant 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/first tier 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	Reason:	
	Change Request / Original Request Denied		
	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 **diagnostic**, how will patient management **change significantly**?	**Specific details required: (Consult note may be required)**
10	If the result is **non-diagnostic,** will patient management change? Patient management will not / is unlikely to change No further investigations	Management will change: Describe in detail (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	Impact of this testing **for at-risk relatives**? Predictive only	Preventive management	Specific screening recommendations / risk reduction strategies:		
18	**Primary** purpose for testing **(select one only):** Confirm / Clarify diagnosis Identify available treatment options available	Recurrence risk for this patient Recurrence risk for other family members			
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)

CLEAR FORM