

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 guardian 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).

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.

PATIENT INFORMATION					
SURNAME		FIRST NAME		INITIALS	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown
BC PERSONAL HEALTH NUMBER		DATE OF BIRTH (YYYY-MMM-DD)		APPLICATION IS FOR <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient, and specify anticipated no. of days _____	
ADDRESS			CITY	PROVINCE	POSTAL CODE

REFERRING PRACTITIONER INFORMATION					
SURNAME		FIRST NAME		MSP NUMBER	
SPECIALTY				E-MAIL ADDRESS	
ADDRESS			CITY	PROVINCE	POSTAL CODE
PHONE NUMBER		ALTERNATE PHONE NUMBER		FAX NUMBER	

REQUEST INFORMATION (Required for all tests)	
1.	Is this request urgent (<i>i.e., is your patient pregnant and results will affect management, or are test results needed for treatment decisions within 6-8 weeks</i>)? <input type="checkbox"/> No <input type="checkbox"/> Yes, please specify. If an explanation is not provided it will be assumed that the request is not urgent. <i>Note: You will be contacted by phone to support an expedient review process.</i>
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 with a BC laboratory physician? <input type="checkbox"/> No <input type="checkbox"/> Yes, please provide the name of the BC laboratory physician(s)

12	If the test result is non-informative, how will this impact your patient management? <input type="checkbox"/> See consultation note <input type="checkbox"/> Other, please specify
13	What are the implications for the patient if testing is not performed? Discuss patient management, genetic counselling, etc. <input type="checkbox"/> See consultation note <input type="checkbox"/> Other, please specify
14	What is the therapeutic impact of this testing for at risk relatives ? <input type="checkbox"/> Preventive management <input type="checkbox"/> Specific screening recommendations or risk reduction strategies <input type="checkbox"/> Identify individuals at risk – little or no change in management <input type="checkbox"/> No individuals at risk Please elaborate on the ramifications.
15	Is genetic or genomic testing involved? <input type="checkbox"/> No <input type="checkbox"/> Yes. Complete the required section below

REQUEST INFORMATION (Required for genetic tests only)	
16	Is there a family history of this condition? <input type="checkbox"/> No <input type="checkbox"/> Yes. Include pedigree as supporting document
17	Has there been a molecular genetic diagnosis made for other family member(s)? <input type="checkbox"/> Not applicable (i.e., no family history) <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes
18	Is the patient at risk because of ethnicity? <input type="checkbox"/> No <input type="checkbox"/> Yes, please specify the ethnic group: _____
19	What is the impact of this testing on genetic counselling ? <input type="checkbox"/> Prenatal diagnosis for reproductive management <input type="checkbox"/> Carrier or predictive testing for reproductive management <input type="checkbox"/> Carrier or predictive testing for long-term / lifestyle planning <input type="checkbox"/> Information only

I hereby declare that the information provided in the application to be accurate

Signature of Referring Practitioner	Date (YYYY/MMM/DD)
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Internal Use Only		
OOP/OOC APPLICATION NUMBER	DATE RECEIVED	STAFF INITIAL