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 ☐Male ☐Female ☐Unknown
BC PERSONAL HEALTH NUMBER	DATE OF BIRTH (YYYY-MMM-DD)	APPLICATION IS FOR ☐Outpatient ☐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.e., is your patient pregnant **and** results will affect management, **or** are test results needed for treatment decisions within 6-8 weeks)*? ☒No ☐Yes, please specify. If an explanation is not provided it will be assumed that the request is not urgent. *Note: You will be contacted by phone to support an expedient review process.*
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.**)** Suspected but not confirmed diagnosis of autosomal dominant polycystic kidney disease
3.	Has this request been discussed with a BC laboratory physician? ☒No ☐Yes, please provide the name of the BC laboratory physician(s)

4.	Name(s) and specialty(s) of other BC and Canadian specialist(s) consulted for this medical condition, if applicable. N/A
5.	Name of laboratory test or genetic test requested. Specify condition or differential for genetic testing. Polycystic kidney disease panel
6.	Do you have a preferred test method? ☐No ☒Yes, please specify testing method details. Next gen sequencing panel with deletion/duplication testing
7.	Do you have a preferred testing laboratory? ☐No ☒Yes, please specify the name and address of the laboratory. Blueprint Genetics Provide rationale for your preferred laboratory (check all that applies). ☐Previously used with success ☒Optimal price ☒Superior testing method quality ☒Other, please specify Up to five (5) free family variant tests for 6 months after report
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? ☐No ☒None that I am aware of ☐Yes, please list the test(s)
10	Have you requested this test for a *different* patient before? ☐No ☐Yes
11	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 **Please provide specific details regarding your selection (required):** ☒See consultation note ☐Other, please specify There is disease modifying treatment and screening (personal and family) available which is proven to improve renal outcomes in ADPKD, but this is only applicable if the diagnosis of ADPKD is confirmed

12	If the test result is non-informative, how will this impact your patient management? ☐See consultation note ☐Other, please specify May request medical genetics involvement for further insight depending on result.
13	What are the implications for the patient if testing is not performed? Discuss patient management, genetic counselling, etc. ☐See consultation note ☐Other, please specify May not be able to initiate the above disease modifying treatment and screening.
14	What is the therapeutic impact of this testing **for at risk relatives**? ☐Preventive management ☒Specific screening recommendations or risk reduction strategies ☐Identify individuals at risk – little or no change in management ☐No individuals at risk **Please elaborate on the ramifications.** Diagnosis and inheritance pattern will be confirmed in the family, screening of at risk family members specific to underlying diagnosis.
15	Is genetic or genomic testing involved? ☐No ☒Yes. Complete the required section below

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

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

Signature of Referring Practitioner	Date (YYYY/MMM/DD)

Internal Use Only		
OOP/OOC APPLICATION NUMBER	DATE RECEIVED	STAFF INITIAL