



KRAS Mutation Test Requisition

*Molecular Biology Laboratory
Department of Laboratory Medicine
St. Michael's Hospital, Room CC 2-101
30 Bond Street, Toronto, ON, M5B 1W8
Telephone: 416-864-6060, Ext.6298
Fax: 416-864-5648*

Patient Information:

First Name: _____

Last Name: _____

Middle Name: _____

Hospital ID #: _____

Date of Birth: _____

HIN #: _____

Request Date: _____

Male Female

Note:

- 1- A complete requisition is required.
- 2- A hard copy of the requisition must be faxed to St. Michael's Hospital (416-864-5648) with original Pathology Report.
- 3- The hard copy must be signed by the Oncologist.

- This patient has been diagnosed with metastatic colorectal cancer
- This patient has failed on fluoropyrimidine-, oxaliplatin-, and irinotecan containing chemotherapy regimens
- This patient will be prescribed Vectibix™ if the results of the test indicates the tumour has a non-mutated (wild type) K-ras

Ordered by:

Physician Name: _____ Clinic: _____

Street Address: _____

Province: _____ Postal Code: _____

Telephone: _____ Fax: _____ E-Mail: _____

Colon Cancer Rectal Cancer

Surgery Date: _____ Location (Hospital Name) _____

Hospital Address: _____

Hospital/Lab Telephone Number: _____ Hospital/Lab Fax Number: _____

- Original Pathology report will be faxed to St. Michael's Hospital along with this requisition.
- The Oncologist will arrange to send to St. Michael's Hospital a paraffin block containing tumour tissue.

Laboratory Use Only:

Specimen ID #: _____
Date Request Received: _____
Type of Sample: Block Slides # Of Slides: _____
Date Specimen Received: _____

PHYSICIAN SIGNATURE: _____