ONCOHELIX

Testing site:
Hematology Translational Lab (HTL)
HMRB336, 3330, Hospital Drive NW, Calgary, AB. T2N4N1
Phone: 403-2207671, 403-2103935, Fax: 403-2108176,
Email: HTL@ucalgary.ca

PATIENT'S INFORMATION

Name (Last, First) ....
Medical Record # ....
Date of Birth (yyyy-mm-dd):................................ Gender: ☐ M ☐ F
Address:...
City, Province:...Country..................................

Please send the filled requisition form by email to precision.diagnostics@oncohelix.org or by fax to (403) 210-8176

ORDER INFORMATION

Requesting Physician.. Location/Facility...
Street Address... City .... Province .... Postal code ....
Phone.............................. Fax .... Email .... Report delivery method ☐ Email ☐ Fax

DIAGNOSIS

Diagnosis (specify)	....
Disease status (select applicable)	☐ Diagnosis ☐ Follow-up ☐ Monitoring ☐ Other (specify) ....

TEST REQUEST

CYTOKINE/SOLUBLE RECEPTOR PROFILE

☐ Regular (2 weeks TAT)	☐ STAT (48 hrs TAT)	☐ 34-Plex cytokine panel ☐ Enhanced Panel (34+2 Plex)	☐ 2-Plex soluble receptor panel (sIL2Ra and sCD163) ☐ Single Cytokine (specify): ....

34-Plex Cytokine Panel

Specimen compatibility: Serum collected from peripheral blood and immediately frozen at -20 ^{0}C

Analytes (pg/mL and reference ranges): Eotaxin/CCL11, GM-CSF, GRO alpha/CXCL1, IFN alpha, IFN gamma, IL-1 beta, IL-1 alpha, IL-1RA, IL-2, IL-4, IL-5, IL-6, IL-7, IL-8/CXCL8, IL-9, IL-10, IL-12 p70, IL-13, IL-15, IL-17A, IL-18, IL-21, IL-22, IL-23, IL-27, IL-31, IP-10/CXCL10, MCP-1/CCL2, MIP-1 alpha/CCL3, MIP-1 beta/CCL4, RANTES/CCL5, SDF1 alpha/CXCL12, TNF alpha, TNF beta/LTA.

2-Plex Soluble Receptor Panel

Analytes (pg/mL or ng/mL and reference ranges): sIL2Ra and sCD163

PAYMENT OPTIONS

☐ **Facility***	Name of the facility .... Address: ....
☐ **Self Pay**	Contact Name: .... Phone: .... Email: ....

* If the contract between OncoHelix and your facility is not in place, please contact: precision.diagnostics@oncohelix.org

CERTIFICATE OF MEDICAL NECESSITY/CONSENT/TEST AUTHORIZATION & PHYSICIAN SIGNATURE

My signature constitutes a Certificate of Medical Necessity, certifies that this test information will inform the patient's ongoing treatment plan, and that I am the patient's treating physician. I have explained to the patient the nature and purpose of the testing to be performed and have obtained informed consent, to the extent legally required, to permit OncoHelix to (a) perform the testing specified herein, (b) retain the test results for an indefinite period for internal quality assurance/operations purposes, and (c) de-identify the test results and use or disclose such de-identified results for future unspecified research or other purposes

....	....	....
Ordering Physician signature	Printed Name	Date

IMPORTANT INFORMATION

Panels	Refer to Cytokine/soluble receptor panel descriptions for list of analytes
Specimens	Refer to sample requirements, guidelines and shipping instructions on page 3

LABORATORY USE

Sample Received ....(yyyy-mm-dd) ....(AM/PM)
Specimen type ....
Tubes/amount ....
Lab Acc# ....

ONCOHELIX

SAMPLE REQUIREMENT & GUIDELINES

Cytokine Profile

Specimen Type	☐ Frozen Serum
Guidelines (Steps outlined must be stringently followed for specimen collection, shipping and handling)	1. Collect peripheral blood in a tube with no anticoagulant (Red top tube) 2. Leave at room temperature for 30 minutes to allow it to clot ☐ Yes ☐ No 3. Centrifuge at 1000g for 10 minutes at room temperature 4. Collect serum in screw cap tube / cryo vial and freeze at -20 °C immediately ☐ Yes ☐ No 5. Minimum requirement is 200 µL

SPECIMEN TYPE	SHIPPING AND HANDLING INSTRUCTIONS	REJECTION CRITERIA
Frozen serum	• Ship at -20^{0}C (use dry ice)	• Hemolyzed specimen

Important Information

1. Please ensure to send filled requisition with the specimens
2. Please fill the following information:

Date of collection ………………………………	Time of collection …………………………………	Collected by ……………………………………………

Shipping Address

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