FORM for Life Labs CEA TESTING under OHIP

This form must be signed by the physician for a CARCINOEMBRYONIC ANTIGEN test or the patient will be required to pay for the testing.

Pre-Test Preparation:

CEA assays are funded by the Ontario Cancer Treatment and Research Foundation for those who meet the criteria listed on the OCTRF CEA requisition (Do not repeat more often than every 28 days).

Patients who do not fit the criteria will be billed for testing.

Specimen Handling:

Collect blood. Allow blood to clot at room temperature for 30 minutes and separate by centrifugation. Transfer an aliquot of serum to a labelled tube, and cap tightly.

Specimen must be accompanied with OCTRF CEA requisition completed by physician stating reason for requesting CEA ASSAY (Patient is currently receiving **follow-up of Stage II or III colorectal cancer**).

Storage: Refrigerated (2-8°C)

Transportation: Refrigerated

TDG: Exempt Human Specimen

Source: http://tests.lifelabs.com/test_information.aspx?id=28215&view=collection

Ontario Cancer Treatment and Research Foundation
CEA Requisition Form

(Addressograph)

Patient Name: _____

Date of Birth: ___ / ___ / _____ (dd/mm/yyyy)

Ontario Health Insurance Number:

___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___

Reason for ordering CEA assay according to OCTRF policy, July 1996.
(Do not repeat more often than 28 days.)

☐ Pre-operative level for patient with clinical diagnosis of colorectal cancer.

☐ Patient is currently receiving adjuvant therapy or follow-up of Stage II or III colorectal cancer.

☐ Patient is currently receiving treatment for metastatic colorectal disease. This is the most appropriate way to monitor response. *(Do not repeat more often than every 2 cycles of therapy.)*

☐ Patient is being treated for metastatic breast cancer. This is the most appropriate way to monitor therapy.

CEA assays are funded by the OCTRF for those patients who meet the above criteria only.

☐ Patient does not fit the above criteria but is willing to pay for the testing.

Signature of clinician: _____

Printed name of clinician: _____

Telephone number: _____ Date: _____