# Canadian Cholangiocarcinoma Collaborative (C3) x UHN Laboratory Medicine Program Molecular Testing Program Checklist

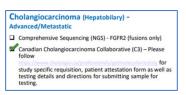
\*Please submit this form with your test requisition form and sample to UHN\*

### Required eligibility criteria:

- Patient is an Ontario resident
- □ Biliary Tract Cancer (i.e., intrahepatic, extrahepatic, gallbladder)
- □ Unresectable locally advanced <u>OR</u> metastatic
- □ Previously treated (progressed on First Line)
- □ Must be a C3 member (refer patient to contact C3 at <u>www.cholanigo.ca</u> to get started)\*

#### **Submission Checklist:**

- □ 1. Completed UHN Test Requisition Form (TRF)
  - On page 2/5, please check:



- 2. Completed C3 Attestation Form for Physicians and Patients
- □ 3. Sample adheres to requirements found on Page 1 of UHN TRF
- □ 4. Submit #1-3 to the address found on UHN TRF along with the Sample
- □ 5. Notify the C3 by filling out this form (<u>click here</u>) or scanning the QR code:

## **C3** Attestation for Physicians and Patients

## Physicians:

I, \_\_\_\_\_\_, confirm that my patient, \_\_\_\_\_\_, is eligible and has agreed to this request for molecular testing from UHN Laboratory Medicine Program with an associated Patient Report. I have informed them about the Canadian Cholangiocarcinoma Collaborative (C3) and how to contact the C3 (<u>www.cholangio.ca</u>). They have given me permission to share their contact information with the C3.

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Patients:

I acknowledge that I need to contact the C3 <u>before</u> the testing can be completed. Should I not reach out in a timely manner, I permit the C3 to contact me.

Patient's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Patient's Email or phone number: \_\_\_\_\_

**OR** The patient has given verbal consent obtained by ordering physician  $\Box$  **YES** 



