Referring Laboratory or Institution:

_____

Send sample to:

Department of Pathology and Lab. Medicine
The Ottawa Hospital-General Campus.
Division of Biochemistry
501 Smyth Road
Ottawa, ON, K1H 8L6

Patient No. Location

Patient Name:

Address:

Ins. No.

DOB: (YY/MM/DD) Sex: Doctor:

Collection Date Time: By:

CANCER CARE ONTARIO
Regional Requisition For CEA (Carcinoembryonic Antigen)

Patient Name: _____

Address: _____

Health Insurance No.

INDICATE REASON FOR ORDERING CEA ASSAY ACCORDING TO CANCER CARE ONTARIO POLICY
(Do not repeat more than every 28 days)

- ☐ Pre-operative for patient with clinical diagnosis of colorectal cancer
- ☐ Patient is currently receiving adjuvant therapy or follow-up for Stage II or III **colorectal cancer**
- ☐ Patient is currently receiving treatment for metastatic colorectal disease. This is the most appropriate way to monitor response (not more frequently than every 2 cycles of treatment)
- ☐ Patient being treated for metastatic **breast cancer**. This is the most appropriate way to monitor response to therapy

Signature of Clinician: _____

Printed Name of Clinician: _____

Telephone Number: _____ Date: _____

Please note: CEA Assays are funded *only* for those patients who meet the above criteria.

This completed requisition must be sent to the Laboratory each time a CEA Assay is ordered. The Laboratory is only funded for patients who meet one of the above criteria. Referring laboratories will be billed for specimens received without a completed form or if the patient does not meet the approved.