CEA REQUISITION FORM

PATIENT NAME: _____

DATE OF BIRTH: _____ (DD/MM/YR) SEX: _____

ONTARIO HEALTH INSURANCE NUMBER: _____

REASON FOR ORDERING CEA ASSAY (Do not repeat more often than every 28 days)

Please check the appropriate box:

- ☐ Patient being treated for metastatic breast cancer. This is the most appropriate way to monitor response to therapy.
- ☐ Patient is currently receiving adjuvant therapy for resected colorectal cancer or being treated for metastatic disease. This is the most appropriate way to monitor response to therapy.
- ☐ Pre-operative level for patient with clinical diagnosis of colorectal cancer.
- ☐ Patient is currently receiving adjuvant therapy or follow-up Stage II or III colorectal cancer.

PLEASE NOTE: CEA Assays are funded by Ontario Cancer Treatment and Research Foundation (OCTRF) for those patients who meet the above criteria only.

- ☐ Patient does not fit the above criteria but is willing to pay the fee of $35 for this test.

Signature of Clinician: _____

Printed Name of Clinician: _____

Telephone Number: _____ DATE: _____