LifeLabs
Medical Laboratory Services

CEA REQUISITION

PATIENT'S NAME: _____

DATE OF BIRTH: ____/_____/_____ (DD/MON/YYYY) SEX: _____

ONTARIO HEALTH INSURANCE NUMBER: __/__/__/__/__/__/__/__/__/__/__/__ Health Number Version

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 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: _____

This completed requisition must accompany the patient each time a CEA assay is requested.