Sunnybrook
HEALTH SCIENCES CENTRE

CEA AUTHORIZATION FORM

Name of Ordering Institution:_______________________________________

Patient Name: ____

Patient date of Birth: ____

Health Card Number: ____

Patient Address: ____

Collection Date: _____________________ Collection Time:_______________

REASON FOR ORDERING CEA ASSAY ACCORDING TO OCTRF POLICY, JULY 1996. (Do not repeat more often than every 28 days).
Please check appropriate box:

- □ 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.

Date of last CEA test: ________________________________

CEA test performed by: ________________________________

PLEASE NOTE: CEA Assays are funded by Cancer Care Ontario ONLY for those patients who meet the above criteria and who are in the original region Sunnybrook was funded for. If you patient does not fall into one of the above categories and you wish the CEA test to be done, please check the box below.

- □ Patient is not included in an approved category but agrees to pay the fee of $30.00 for this test.

Signature of Clinician: ____

Printed Name of Clinician: ____

Telephone Number: ___________________________ Date:_______________________

This completed requisition MUST be sent to the laboratory each time a CEA assay is ordered. Unless this form is submitted, the laboratory will not do the testing. If any information is missing, the ordering site will be billed $30.00 per test.