Ontario Cancer Treatment and Research Foundation
CEA Requisition Form

(Addressograph)

Patient Name: _____

Date of Birth: _____/_____/_____ (dd/mm/yr)

Ontario Health Insurance Number:

___|___|___|___|___|___|___|___|___|___

Reason for ordering CEA assay according to OCTRF policy, July 1996.
(Do not repeat more often than 28 days.)

____ Pre-operative level for patient with clinical diagnosis of colorectal cancer.

____ Patient is currently receiving adjuvant therapy or follow-up of Stage II or III colorectal cancer.

____ Patient is currently receiving treatment for metastatic colorectal disease. This is the most appropriate way to monitor response. *(Do not repeat more often than every 2 cycles of therapy.)*

____ Patient is <u>being treated</u> for metastatic breast cancer. This is the most appropriate way to monitor therapy.

CEA assays are funded by the OCTRF for those patients who meet the above criteria only.

____ Patient does not fit the above criteria but is willing to pay for the testing.

Signature of clinician: _____

Printed name of clinician: _____

Telephone number: _____ Date: _____