NOTE DE SERVICE
MEMORANDUM

OPTILAB Montréal-CUSM

date:	**2025-04-14**
à:	**Tous les médecins prescripteurs (surtout : Neurologues et Rhumatologues)**
to:	***All Ordering Physicians (mainly : Neurologists and Rheumatologists)***
de:	**Dr. B.M. Gilfix, MDCM, PhD, FRCPC, DABCC, FADLM**
from:	Responsable des envois / *Responsible for Send Out*
objet:	**Changement de site de test pour les tests hors province pour certaines maladies auto-immunes de MitogenDx à In-Common Laboratories**
subject:	***Change In Testing Sites for Out of Province Tests for Certain Autoimmune Diseases from MitogenDx to In-Common Laboratories***

ENGLISH WILL FOLLOW

À partir de maintenant, les tests énumérés ci-dessous qui étaient auparavant envoyés à MitogenDx à l'extérieur de la province doivent maintenant être acheminés à In-Common Laboratories.

In-Common Laboratories offre ces tests à des prix inférieurs, propose un menu de tests élargi et offre une plus grande efficacité dans la manipulation.

Pour ces tests, une AH-612 Autorisation Pour Des Services de Biologie Médicale Non Disponibles Au Québec est nécessaire.

Ils nécessitent également une demande In-Common qui est jointe.

Vous trouverez ci-dessous un tableau énumérant les tests concernés.

Si vous avez des questions à ce sujet, veuillez communiquer avec le Service à la clientèle des laboratoires cliniques au 514-934-1934, poste 35687.

Merci de votre compréhension.

Effective immediately, the tests listed below that were previously sent out of province to MitogenDx are now to be directed to In-Common Laboratories.

In-Common Laboratories offers these tests at lower prices, contains an expanded test menu, and offers efficiencies in handling.

For these tests an AH-612 Autorisation Pour Des Services de Biologie Médicale Non Disponsibles Au Québec is required.

They will also require an In-Common requisition which is attached.

Below is a table listing the tests that are affected.

Should you have any questions regarding this matter, please contact Client Services for Clinical Laboratories at 514-934-1934 ext 35687.

Thanks for your understanding

Tests de MitogenDx abandonnés/Discontinued Tests from MitogenDx	***Nouveaux tests de In-Common Laboratories/New Tests from In-Common Laboratories***	**Commentaire/Comment**
Scleroderma / Systemic Sclerosis Panel	*Systemic Sclerosis (Scleroderma, nucleoli) Profile, Serum [SSNAB]*	*Le test par défaut est le CHUM Panel sclérodermie. Le test OOP n'est utilisé que lorsqu'un panel étendu est nécessaire.* *The default test is the CHUM Panel sclerodermie. OOP test is only for when an extended panel is required.*
Systemic Lupus Erythematosus Panel	*Connective tissue Disease-Lupus Profile, Serum [CTDAB S]*	
Autoimmune Liver Disease Panel PLUS	*Autoimmune Liver Disease Profile, Serum [ALDAB S]*	
Neurological Disease Profile [précédemment abandonné/previously discontinued]	*Ganglioside Antibodies Profile IgG & IgM, Serum [GANGM S]*	
Anti-dsDNA by Chemiluminescence Immunoassay	*Double-stranded DNA (dsDNA) Antibodies, Serum/Plasma [DNAAB]*	
Sjorgren Syndrome/Disease Panel	*Sjogren Syndrome Profile, Serum [SSAB S]*	

IN-COMMON LABORATORIES - MANUAL REQUISITION

57 GERVAIS DR., NORTH YORK, ON M3C 1Z2 (416) 422-3000

Client Information: Submit one specimen per test unless otherwise specified in our ICL reference manual

Referring Client: (Name and Address)	Date Sent:

Patient Demographics: Please complete all ** required fields or use a patient specimen label in the designated area (preferred)

ICL Accession Number	*For ICL use only*				**or Place Specimen label here (preferred)**
**Collection Date/Time	Day	Month	Year	Time	
**Patient Name (Last, First)					
**Date of Birth	Day	Month	Year	Sex (M/F)	
**Specimen #/ Patient File #					
**Ordering Physicians Name					

Order/Test Information

Specimen Type: Serum ☐ Plasma ☐ Whole Blood ☐ Urine ☐ Other: (Specify Source)_____	24Hr Urine Volume(L): (if applicable)	** Specimen sent frozen: **Yes** ☐ **No** ☐
Test:	Additional Information	

Patient Demographics: Please complete all ** required fields or use a patient specimen label in the designated area (preferred)

ICL Accession Number	*For ICL use only*				**or Place Specimen label here (preferred)**
**Collection Date/Time	Day	Month	Year	Time	
**Patient Name (Last, First)					
**Date of Birth	Day	Month	Year	Sex (M/F)	
**Specimen #/ Patient File #					
**Ordering Physicians Name					

Order/Test Information

Specimen Type: Serum ☐ Plasma ☐ Whole Blood ☐ Urine ☐ Other: (Specify Source)_____	24Hr Urine Volume(L): (if applicable)	** Specimen sent frozen: **Yes** ☐ **No** ☐
Test:	Additional Information	