

CYTOGENOMICS LABORATORY REQUISITION

Hematological Neoplasia

Vancouver General Hospital
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VGH Cyto genetics Number

Other Case Numbers

| PHYSICIAN INFORMATION | | PATIENT INFORMATION | |
|--|-----------|----------------------------|--|
| ORDERING PHYSICIAN | BILLING # | SURNAME | GIVEN NAME(S) |
| ADDRESS | | DATE OF BIRTH (DD/MM/YYYY) | PHN |
| PHONE # | FAX | GENDER | <input type="checkbox"/> INPATIENT Ward:..... <input type="checkbox"/> OUTPATIENT |
| ADDITIONAL REPORTS TO (include first name or billing #): | | ADDRESS | |

HEMATOLOGIC NEOPLASIA

| | |
|---|---|
| Reason for Testing - REQUIRED | Test Requested: <input type="checkbox"/> Routine <input type="checkbox"/> Priority <input type="checkbox"/> By Date: |
| <input type="checkbox"/> AML <input type="checkbox"/> CLL <input type="checkbox"/> ALL <input type="checkbox"/> MDS <input type="checkbox"/> CML <input type="checkbox"/> MPN <input type="checkbox"/> Multiple Myeloma <input type="checkbox"/> Lymphoma; <i>specify</i> : <input type="checkbox"/> Other; <i>specify</i> : | <input type="checkbox"/> Karyotype <input type="checkbox"/> FISH <input type="checkbox"/> t(9;22) [BCR/ABL1] <input type="checkbox"/> t(15;17) [PML/RARA] <input type="checkbox"/> KMT2A [MLL] <input type="checkbox"/> Multiple Myeloma panel ♦ <input type="checkbox"/> CLL panel <input type="checkbox"/> t(11;14) [CCND1/IGH] <input type="checkbox"/> MYC <input type="checkbox"/> BCL2 <input type="checkbox"/> BCL6 <input type="checkbox"/> XY: Donor is <input type="checkbox"/> Male <input type="checkbox"/> Female |
| <input type="checkbox"/> New Diagnosis <input type="checkbox"/> Follow-up <input type="checkbox"/> Pre-SCT; <i>Date of SCT</i> : Pathologist: | <input type="checkbox"/> PDGFRA <input type="checkbox"/> PDGFRB <input type="checkbox"/> FGFR1 <input type="checkbox"/> JAK2 <input type="checkbox"/> 5q <input type="checkbox"/> 7q <input type="checkbox"/> 8 centromere <input type="checkbox"/> 20q <input type="checkbox"/> Other: <i>Specify</i> |
| <input type="checkbox"/> IGHV Mutational Analysis. Two (2) x 5 mL PB in lavender EDTA tubes | |

Relevant Clinical History (please describe):

ORDERING PHYSICIAN SIGNATURE – REQUIRED

SPECIMEN REQUIREMENTS *Ship at room temperature, courier overnight M-Th only.*

- Bone Marrow:** 2 x 1 mL in collection media, 1st or 2nd pull **AND** 1 unstained, untreated smear
- Bone Core Biopsy:** ≥ 1 cm, if poor aspirate or dry tap; do not use for touch preps
- Blood:** 5 mL Sodium Heparin Blood for Cytogenetics and FISH
- ♦ **Multiple Myeloma:** send 5 untreated, unstained smears
- IGHV MA:** 2 x 5 mL PB in EDTA tube

COLLECTION INFORMATION

Date:..... Time:.....
Location:
Collected by:

CG LABORATORY USE ONLY

Date Received:
Date Incubated:
Log-in Tech:

Tests Performed:

- Karyotype
- FISH
- Mosaicism

SPECIMEN(S) RECEIVED

..... NaHep tube EDTA tube
..... mL BM/tube 1 Top
..... mL BM/tube 2
..... Smears Other

'The personal information collected on this form is collected under the authority of the Personal Information Protection Act. The personal information is used to provide medical services requested on this requisition. The information collected is used for quality assurance management and disclosed to healthcare practitioners involved in providing care or when required by law. Personal information is protected from unauthorized use and disclosure in accordance with the Personal Information Act and when applicable the Freedom of Information and Privacy Act and may be used and disclosed only as provided by those acts.'