

CYTOGENETICS LABORATORY REQUISITION

Hematological Neoplasia

Vancouver General Hospital
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VGH Cytogenetics 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) <input type="checkbox"/> t(8;14) <input type="checkbox"/> t(8;21) <input type="checkbox"/> t(14;18) <input type="checkbox"/> t(15;17) <input type="checkbox"/> PDGFR <input type="checkbox"/> inv(16) <input type="checkbox"/> alpha <input type="checkbox"/> beta <input type="checkbox"/> MLL <input type="checkbox"/> 5q <input type="checkbox"/> t(11;14) <input type="checkbox"/> 7q <input type="checkbox"/> Multiple Myeloma panel ♦ <input type="checkbox"/> 8 centromere <input type="checkbox"/> CLL panel <input type="checkbox"/> 20q <input type="checkbox"/> MYC <input type="checkbox"/> XY; <i>Donor:</i> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other; <i>Specify</i>
<input type="checkbox"/> New Diagnosis <input type="checkbox"/> Follow-up <input type="checkbox"/> Pre-SCT; <i>Date of SCT:</i> Pathologist:	<input type="checkbox"/> Molecular (<i>Sample will be forwarded to BCCA Clinical Genetics Lab</i>) ♦ <input type="checkbox"/> Jak2 <input type="checkbox"/> BCR-ABL Baseline PCR

NOTE: Cytogenetic studies represent single asterisk MSP fee items and are subject to review and approval by the Laboratory Physician

Relevant Clinical History (please describe):

ORDERING PHYSICIAN SIGNATURE – REQUIRED

Signature box

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
♦ 20ml EDTA for Molecular testing
- ♦ **Multiple Myeloma:** send also 3-4 untreated, unstained smears

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