| DIAGNOSTIC SERVICES OF MANITOBA / SERVICES DE DIAGNOSTIC DU MANITOBA | *Bone Marrow Review/Consult Request* | | **Document #** F140-50-22 |
|---|---|---|---|
| | | | **Version #** 01 |
| | **Approved by:** Dr. Carmen Morales | **Effective Date:** May 2, 2012 | **Source Document:** 140-50-22 |

# BONE MARROW REVIEW/CONSULT REQUEST

***THIS FORM MUST BE COMPLETED IN ITS ENTIRETY***

_____
DATE OF REQUEST

**REQUESTING PHYSICIAN TO COMPLETE PART A AND FORWARD FORM TO ORIGINAL TESTING SITE.**

**A)** FILL IN THE FOLLOWING:

DATE OF BONE MARROW: _____ (DD/MM/YEAR)

DOCTOR REQUESTING CONSULT: _____

PHONE #: _____

FAX #: _____

PATIENT DEMOGRAPHICS (INSERT ADDRESSOGRAPH IF AVAILABLE)

PATIENT NAME: _____

DATE OF BIRTH: _____
(DD/MM/YYYY)

PHIN: _____

REASON FOR REQUEST/CLINICAL INDICATION/PATIENT HISTORY:

**ORIGINAL SITE WILL COMPLETE PART B, GATHER MATERIAL IN PART C, AND SEND SLIDES AND THIS FORM AS DIRECTED IN PART D**

**B)** COMPLETE **ALL** OF THE FOLLOWING INFORMATION:

TYPE OF PROCEDURE (CHECK): ASPIRATE+BIOPSY ☐ ASPIRATE ONLY ☐ BIOPSY ONLY ☐

SITE: ILIAC CREST ☐ LEFT ☐ RIGHT ☐ STERNAL ☐ OTHER_____

ANCILLARY STUDIES: MOLECULAR ☐ FLOW CYTOMETRY ☐ CYTOGENETICS ☐ NONE ☐

DOCTOR WHO PERFORMED THE BONE MARROW:_____

HOSPITAL/CLINIC WHERE BONE MARROW WAS PERFORMED:_____

**C)** WE REQUIRE **ALL** OF THE FOLLOWING TO COMPLETE THE REVIEW, IF PERFORMED:

- PERIPHERAL BLOOD FILM AND CBC REPORT FROM THE DATE OF PROCEDURE
- ALL BONE MARROW ASPIRATE SLIDES, INCLUDING ANY UNSTAINED SLIDES
- A COPY OF THE BONE MARROW ASPIRATE REPORT
- THE STAINED BONE MARROW BIOPSY SLIDES AND ALL SPECIAL STAINS, IMMUNOHISTOCHEMISTRY SLIDES, AND ASSOCIATED REPORTS.
- A COPY OF THE BONE MARROW BIOPSY REPORT
- TWELVE (12) UNSTAINED BIOPSY SLIDES, OR PREFERABLY, THE BIOPSY BLOCK
- STAINED AND UNSTAINED BONE MARROW BIOPSY IMPRINT SLIDES
- ANCILLARY STUDY REPORTS IF PERFORMED ON THIS MARROW, INCLUDING MOLECULAR/FLOW CYTOMETRY/CYTOGENETICS/FISH

**NOTE:** SUBMITTED MATERIAL SHOULD BE LABELLED WITH THE FIRST AND LAST NAME AND UNIQUE CASE NUMBER. FAILURE TO PROVIDE NECESSARY MATERIAL MAY IMPEDE THE REVIEW PROCESS.

**D)** SEND SLIDES, INFORMATION/REPORTS, AND THIS **COMPLETED FORM** TO:

HSC HEMATOLOGY LAB
MS559 – 820 SHERBROOK STREET
WINNIPEG, MB

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT THE BONE MARROW BENCH AT:
PHONE: 204-787-1051
FAX: 204-787-1623

*** INCLUDE THE FOLLOWING ON THE PACKAGE ***

**DO NOT OPEN**
**DELIVER DIRECTLY TO HEMATOLOGY LAB**
**ATTENTION: BONE MARROW BENCH**