For PDF Fillable Requisitions, the following applies:

1. The form shall be completed using a Digital Health assigned computer.
2. Absolutely no personal health information shall be electronically saved on a computer.
3. The completed form shall not be shared electronically. If you reasonably believe that e-mailing the information is the only available method of communication or the only way to send the information then you must adhere to the Privacy guideline titled "E-mailing Personal Health Information".
4. All forms must be completed in their entirety, e.g. if a staff member has only completed half of a form they cannot save their work and then come back to complete it at a later date.
5. Once the personal health information has been recorded onto the form, it is to be printed immediately, deleted (not saved) from the computer, and then stored securely inside the client (paper) health record or scanned into an electronic record.
6. Do not print unnecessary duplicate copies of the form.
7. Regular audits of the Digital Health assigned computer shall be undertaken to ensure that no personal health information is being duplicated and saved.

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:** 04-MAY-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