

CYTOGENETICS & FISH – HEMATOLOGY / ONCOLOGY REQUISITION

Acceptance Policy 10-50-03: Requirements for Test Requisitions 2.1 - Fields marked with * are mandatory and must be clearly legible or can result in specimen rejection.

Ordering Provider Information		Patient Information	
*Last & Full First Name:	Billing Code:	*Last/First Name: (per Health Card)	
*Ordering Facility:		* Date of Birth (dd/mm/yyyy)	
Address:		*Sex: Female Male	
Critical Results Phone Number:	Fax No.:	*PHIN: (Specify if other province/ DND)	
Physician Signature:	Phone No.:	MRN:	
Copy Report To: (if info missing, report may not be sent)		Encounter Number:	
Last & Full First Name:	Fax No.:	Patient Phone No:	
Facility Name/ Address:	Phone No.:	Patient Address:	
Last & Full First Name:	Fax No.:	Demographics verified:	
Facility Name/ Address:	Phone No.:	<input type="checkbox"/> Health Card <input type="checkbox"/> Armband <input type="checkbox"/> eChart/CR <input type="checkbox"/> Other	

Collection Information (fields marked with ♦ required by person collecting sample)			
♦ Collector:	♦ Collection Facility/Lab:	♦ Collection Date:	♦ Time:

<p><u>Please have all specimens delivered to:</u> Central Services MS551 820 Sherbrook Street Winnipeg Manitoba R3A 1R9</p>	<p><i>Place LIS Sticker Here</i></p>	<p>Additional requisitions / sample requirements at: https://apps.sbg.mb.ca/labmanual/test/findTestPrepare Cyto genetics Laboratory Health Sciences Centre MS635C 820 Sherbrook St., Winnipeg MB R3A 1R9 Phone 204-787-2489 Fax 204-787-1384</p>
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Sample Type & Requirements - Store at room temperature. DO NOT FREEZE.

<input type="checkbox"/> Bone Marrow	2mL in a bone marrow collection tube from laboratory: 204-787-2489	WBC Count: _____x10 ⁹ /L
<input type="checkbox"/> Peripheral Blood	Chromosome Analysis & FISH: 2-4mL in NaHep. Ataxia Telangiectasia: 2-6mL in NaHep. Fanconi Anemia: 2-6mL in NaHep. Sample must be received by noon, the same day of collection, Monday to Thursday.	
<input type="checkbox"/> Bone Core Biopsy	Specimen collected aseptically, placed in a bone marrow collection tube from laboratory: 204-787-2489.	
<input type="checkbox"/> Lymph Node	Specimen collected aseptically, placed in sterile culture medium. Transport immediately; refrigerate if shipping delayed.	
<input type="checkbox"/> FFPE Tissue	Block No.: _____ Specimen Id: _____ Source/Site: _____ FFPE tissue slides for FISH: cut at 4µm. Must be accompanied with an H&E recut, marked with the region of interest.	
<input type="checkbox"/> Other		

Test(s) Requested	Indication for Study	
<input type="checkbox"/> Chromosome Analysis <input type="checkbox"/> Diagnostic <input type="checkbox"/> Follow Up	<input type="checkbox"/> Chronic lymphocytic leukemia (CLL) (NOT including MCL)	<input type="checkbox"/> Myeloproliferative neoplasm (MPN)
	<input type="checkbox"/> Mantle cell lymphoma (MCL)	<input type="checkbox"/> Myelodysplastic syndrome (MDS)
	<input type="checkbox"/> Chronic myeloid leukemia (CML)	<input type="checkbox"/> Acute promyelocytic leukemia (APL)
<input type="checkbox"/> Fix and store	<input type="checkbox"/> Acute myeloid leukemia (AML)	<input type="checkbox"/> Burkitt lymphoma
<input type="checkbox"/> Chromosome Breakage (Oncologist only): <input type="checkbox"/> Ataxia Telangiectasia <input type="checkbox"/> Fanconi Anemia	<input type="checkbox"/> Acute lymphoblastic leukemia (ALL)	<input type="checkbox"/> Other:
	Additional Information:	
<input type="checkbox"/> ¹ FISH		

¹FISH can only be ordered by a Cytogeneticist, Pathologist, Clinical Hematologist or Medical Oncologist. Please arrange for a clinical consult as required. Other FISH requests may be available for testing by send-out only and are to be discussed with a Cytogeneticist/Hematopathologist.

CYTOGENETICS LAB USE ONLY		Genomics LIS Label
Computer Code: _____	Status Code: _____	
Laboratory No.: _____	Date Sample Received: _____	