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.

Please have all specimens delivered to: Central Services MS551 820 Sherbrook Street Winnipeg Manitoba R3A 1R9	Additional requisitions / sample requirements at: https://apps.sbgh.mb.ca/labmanual/test/findTestPrepare Cytogenetics Laboratory Health Sciences Centre MS635C 820 Sherbrook St., Winnipeg MB R3A 1R9 Phone 204-787-2489 Fax 204-787-1384	*Place LIS Sticker Here*

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		
*Last & First Name:		Billing Code:
*Ordering Facility:		Inpatient Location:
Address:		
Critical Results Phone Number:		Fax No.:
Physician Signature:		Phone No.:
Copy Report To: *(if info missing, report may not be sent)*		
Last & First Name:		Fax No.:
Facility Name/ Address:		Phone No.:
Last & First Name:		Fax No.:
Facility Name/ Address:		Phone No.:

Patient Information

*Last/First Name:
(as (per Health Card)
* Date of Birth (dd/mm/yyyy)
*Sex: ☐ Female ☐ Male
*PHIN:
(Specify if other province/ DND)
MRN:
Encounter Number:
Patient Phone No:
Patient Address:

Demographics verified:
❑ Health Card ❑ Armband ❑eChart/CR ❑ Other

Collection Information (*fields marked with ♦ required by person collecting sample*)

* Collector:	* Collection Facility/Lab:	* Collection Date:	* Time:

Sample Type & Requirements - *Store at room temperature. DO NOT FREEZE.*

☐ Bone Marrow	2mL in a bone marrow collection tube from laboratory: 204-787-2489	WBC Count: _____x10^9/L
☐ Peripheral Blood	2-4mL in NaHep.	
☐ Bone Core Biopsy	Specimen collected aseptically, placed in a bone marrow collection tube from laboratory: 204-787-2489.	
☐ Lymph Node	Specimen collected aseptically, placed in sterile culture medium. Transport immediately; refrigerate if shipping delayed.	
☐ FFPE Tissue	Block No.: _____ Specimen Id: _____ Source/Site: _____ FFPE tissue slides for FISH: cut at 3µm. Must be accompanied with an H&E recut, marked with the region of interest.	
☐ Other		

Test(s) Requested	**Indication for Study**	
☐ Chromosome Analysis	☐ Chronic lymphocytic leukemia (CLL) (NOT including MCL)	☐ Myeloproliferative neoplasm (MPN)
☐ Diagnostic	☐ Mantle cell lymphoma (MCL)	☐ Myelodysplastic syndrome (MDS)
☐ Follow Up	☐ Chronic myeloid leukemia (CML)	☐ Acute promyelocytic leukemia (APL)
☐ Fix and store	☐ Acute myeloid leukemia (AML)	☐ Triple Hit lymphoma
☐ [1]FISH	☐ Acute lymphoblastic leukemia (ALL)	☐ Other:
For chromosome breakage studies, please use Constitutional requisition R250-10-71.	Additional Information:	

[1]FISH 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			
Computer Code: _____	Status Code: _____	*Genomics LIS Label*
Laboratory No.: _____	Date Sample Received: _____	