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: _____	