FLOW CYTOMETRY LABORATORY REQUISITION

****REQUISITION MUST ACCOMPANY SPECIMEN TO FLOW CYTOMETRY LABORATORY ****

Shared health Soins communs Manitoba

Acceptance Policy 10-50-03 - Requirements for Test Requisitions 2.1 - All information marked with an * is mandatory and must be clearly legible. Failure to comply may result in specimen rejection.

ORDERING PROVIDER INFORMATION	
***Last & Full First Name:**	**Billing Code:**
***Ordering Facility:**	**Inpatient Location:**
Address:	
Critical Results Phone Number:	***Fax Number:**

COLLECTION INFORMATION
Copy of report to Lab ❑ **YES** ❑ **NO**
***Collection Facility/Lab:**
***Collection Date:**
***Collection Time:**
Referring Lab: **Check if samples shipped frozen** ❑
Number of tubes sent: Serum vial(s) ____ Plasma vials(p) ____

PATIENT INFORMATION
*Last/First Name: (as per MB Health Card)
* Date of Birth (dd/mm/yyyy)
*Sex: Female Male
*PHIN:
*Alternate ID: **(include ID type with number ie. RCMP, SK, DND)**
MRN:
Encounter Number:
Demographics verified with: ❑ **Prov. Health Card** ❑ **Armband** ❑**eChart/CR**
*Patient Phone No:
*Patient Address:

ADDITIONAL REPORT RECIPIENT PROVIDER INFORMATION	
Last & Full First Name:	**Billing Code:**
Phone #:	**Fax #:**

ADDITIONAL REPORT RECIPIENT PROVIDER INFORMATION	
Last & Full First Name:	**Billing Code:**
Phone #	**Fax #:**

***Clinical Information/Diagnosis:**

□ Lymphoma □ CLL □ Sezary Syndrome □ Hairy Cell

□ Mastocytosis □ Immune Deficiency □ Acute Leukemia

□ Other: _____

Recent Transfusion: □ No □ Yes Date: _____

Current Radiation/Chemotherapy Treatment: □ No □ Yes

Monoclonal Antibody Therapy: □ No □ Yes Generic Name: _____

LIS BARCODE LABEL

***Must be included for all testing excluding PB48 and FLFC**

□ **CBC with Automated Diff – Results Attached** □ **CBC with Automated Diff – Sent for Testing at Shared Health Site**

Immune Monitoring		
□ **PB48**	CD4 Count (CD3, CD4, CD8)	EDTA (< 48 hr)
□ **PBLS**	Lymphocyte Subset Enumeration (T, B, NK)	EDTA (< 48 hr)

Immunodeficiency Investigation		
□ **RTE4**	CD4+ Recent Thymic Emigrants *(Includes Naïve and Memory T Cells)*	EDTA (< 48 hr)
□ **PBBS**	Advanced B Cell Phenotyping	EDTA (< 48 hr)
□ **PBTS**	Advanced T Cell Phenotyping	EDTA (< 48 hr)
□ **TREG**	Regulatory T Cells	EDTA (< 24 hr)
□ **LAD**	Leukocyte Adhesion Deficiency *(Type I and II)*	EDTA (< 24 hr)
□ **OBRT**	Neutrophil Function – Oxidative Burst ***(Microtainer collections will be rejected)***	EDTA (< 24 hr)

Leukemia/Lymphoma Investigation		
□ **PBFC**	Peripheral Blood Immunophenotyping ***(Send 1 Unstained Smear)***	EDTA (< 72 hr)
□ **FLFC**	Fluid Immunophenotyping ***(CSF ONLY)***	RPMI (< 72 hr)

Miscellaneous		
□ **PNH**	Paroxysmal Nocturnal Hemoglobinuria	EDTA (< 48 hr)
□ **HSFC**	Hereditary Spherocytosis ***(Send 1 Unstained Smear)***	EDTA (< 48 hr)
□ **MIS8**	Referral tests require prior approval. Complete the Immunology/Hematology Approval for Testing Form [F150-100-100]	

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Additional requisitions and sample requirements available at:
https://apps.sbgh.mb.ca/labmanual/