

FLOW CYTOMETRY LABORATORY REQUISITION

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

*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		PATIENT INFORMATION	
*Last & Full First Name:	Billing Code:	*Last/First Name: (as per MB Health Card)	
*Ordering Facility:	Inpatient Location:	* Date of Birth (dd/mm/yyyy)	
Address:		*Sex: Female Male	
Critical Results Phone Number:	*Fax Number:	*PHIN:	
COLLECTION INFORMATION		ADDITIONAL REPORT RECIPIENT PROVIDER INFORMATION	
*Collection Facility/Lab:		*Alternate ID: (include ID type with number ie. RCMP, SK, DND) MRN:	
*Collection Date:		Encounter Number:	
*Collection Time:		Demographics verified with: <input type="checkbox"/> Prov. Health Card <input type="checkbox"/> Armband <input type="checkbox"/> eChart/CR	
Referring Lab: <input type="checkbox"/> Check if samples shipped frozen <input type="checkbox"/>		Patient Phone No:	
Number of tubes sent: Serum vial(s) _____ Plasma vials(p) _____		Patient Address:	
ADDITIONAL REPORT RECIPIENT PROVIDER INFORMATION		ADDITIONAL REPORT RECIPIENT PROVIDER INFORMATION	
Last & Full First Name:	Billing Code:	Last & Full First Name:	Billing Code:
Phone #:	Fax #:	Phone #:	Fax #:

<p>*Clinical Information/Diagnosis:</p> <p> <input type="checkbox"/> Lymphoma <input type="checkbox"/> CLL <input type="checkbox"/> Sezary Syndrome <input type="checkbox"/> Hairy Cell <input type="checkbox"/> Mastocytosis <input type="checkbox"/> Immune Deficiency <input type="checkbox"/> Acute Leukemia <input type="checkbox"/> Other: _____ </p> <p>Recent Transfusion: <input type="checkbox"/> No <input type="checkbox"/> Yes Date: _____</p> <p>Current Radiation/Chemotherapy Treatment: <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Monoclonal Antibody Therapy: <input type="checkbox"/> No <input type="checkbox"/> Yes Generic Name: _____</p>	LIS BARCODE LABEL
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***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		
<input type="checkbox"/> PB48	CD4 Count (CD3, CD4, CD8)	EDTA (< 48 hr)
<input type="checkbox"/> PBLS	Lymphocyte Subset Enumeration (T, B, NK)	EDTA (< 48 hr)

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

Leukemia/Lymphoma Investigation		
<input type="checkbox"/> PBFC	Peripheral Blood Immunophenotyping (<i>Send 1 Unstained Smear</i>)	EDTA (< 72 hr)
<input type="checkbox"/> FLFC	Fluid Immunophenotyping (<i>CSF ONLY</i>)	RPML (< 72 hr)

Miscellaneous		
<input type="checkbox"/> PNH	Paroxysmal Nocturnal Hemoglobinuria	EDTA (< 48 hr)
<input type="checkbox"/> HSFC	Hereditary Spherocytosis (<i>Send 1 Unstained Smear</i>)	EDTA (< 48 hr)
<input type="checkbox"/> 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.sbggh.mb.ca/labmanual/>