MOLECULAR HEMATOPATHOLOGY TEST REQUISITION

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

***** PLEASE COMPLETE THE INFORMATION BELOW. PRINT CLEARLY. CHECK APPROPRIATE PROFILE *****

ORDERING PROVIDER INFORMATION	
***Last & Full 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 & Full First Name:	**Fax No:**
Facility Name/Address:	**Phone No:**
Last & Full First Name:	**Fax No:**
Facility Name/Address:	**Phone No:**

PATIENT INFORMATION

*Last/First Name: (per MB. Health Card)

* Date of Birth (dd/mm/yyyy)

*Sex: Female Male

*PHIN:

Specify if other province or DND

MRN:

Encounter Number:

Patient Phone No:

Patient Address:

Demographics verified with: ❑ Prov. Health Card ❑ Armband ❑eChart/CR

COLLECTION INFORMATION (fields marked with ♦ required by person collecting sample)

♦ Collector:	♦ Collection Date:	♦ Collected Via: ❑ Venipuncture ❑ Capillary ❑ Indwelling Line ❑ Above shut off IV
♦ Collection Facility/Lab:	♦ Collection Time:	

Serum vial(s) _____ # Plasma vials (p) _____ | Referring Lab: Number of tubes sent ____ | Samples shipped frozen ❑

SAMPLE TYPE

- ☐ **Peripheral Blood** **Case #** _____
- ☐ **Bone Marrow** **Case #** _____
- ☐ **Formalin-fixed Paraffin-embedded Tissue** **Case #** _____
- ☐ **Fresh/Frozen Tissue** **Case #** _____
- ☐ **Other** _____

Clinical History

	TEST NAME and PURPOSE	TESTING SITE	CODE
☐	**Factor V Leiden and Prothrombin G20210A Mutation** Hypercoaguability/Thrombophilia (diagnostic)	HSC	MOL
☐	**B Cell Clonality, Immunoglobulin Gene Arrangement** B cell lymphoma (diagnostic)	HSC	HMD
☐	**T-Cell Clonality, T Cell Receptor Gene Rearrangement** T cell lymphoma (diagnostic)	HSC	HMD
☐	**BCR/ABL1 Diagnostic Screen (non-quantitative), t(9;22), Philadelphia Chromosome** CML, ALL (diagnostic)	HSC	HMD
☐	**BCR/ABL1 Quantitative Monitoring, RQ BCR/ABL1,** CML, ALL (follow-up)	HSC	HMD
☐	**PML/RARA Diagnostic Screen (non-quantitative), t(15;17)** APT (diagnostic and follow-up)	HSC	HMD
☐	**RUNX/RUNX1T1 (AML1/ETO) Rearrangement, t(8;21)** AML (diagnostic)	HSC	HMD
☐	**CBFB/MYH11 Rearrangement, inv(16),** AML (diagnostic)	HSC	HMD
☐	**ETV6/RUNX1 (TEL/AML1) Rearrangement, t(12;21)** ALL (diagnostic)	HSC	HMD
☐	**JAK2 V617F Mutation (quantitative)** Myeloproliferative neoplasm (diagnostic)	HSC	JAK2
☐	**FLT3/NPM1 for AML** AML (diagnostic)	HSC	HMD

Previous Testing

Other Testing Requirement

	TEST NAME and PURPOSE	TESTING SITE	CODE
☐	**ABL1 Tyrosine Kinase Inhibitor Resistance Screen** CML, ALL (prognostic)	Mayo	HMD
☐	**CEBPA Mutation Testing for AML** AML (diagnostic)	Mayo	HMD
☐	**CALR** Myeloproliferative Neoplasm (MPN)	Mayo	HMD
☐	**C-KIT D816 Point Mutation Analysis** Mastocytosis (diagnostic)	Stanford	HMD
☐	**C-KIT Sequencing Analysis** AML (diagnostic)	Stanford	HMD

Prognostic testing requires a funding approval letter from the applicable Regional Health Authority.

Submit samples and completed requisition to:

Shared Health Hematopathology Molecular Laboratory

Health Sciences Centre, MS559 – 820 Sherbrook Street

Winnipeg, MB R3A 1R9