

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		PATIENT INFORMATION	
*Last & Full First Name:	Billing Code:	*Last/First Name: (per MB. Health Card)	
*Ordering Facility:	Inpatient Location:	* Date of Birth (dd/mm/yyyy)	
Address:		*Sex: Female Male	
Critical Results Phone Number:	Fax No:	*PHIN:	
Physician Signature:	Phone No:	Specify if other province or DND	
COPY REPORT TO: (if info missing, report may not be sent)			
Last & Full First Name:	Fax No:	MRN:	
Facility Name/Address:	Phone No:	Encounter Number:	
Last & Full First Name:	Fax No:	Patient Phone No:	
Facility Name/Address:	Phone No:	Patient Address:	
		Demographics verified with: <input type="checkbox"/> Prov. Health Card <input type="checkbox"/> Armband <input type="checkbox"/> eChart/CR	

COLLECTION INFORMATION (fields marked with ♦ required by person collecting sample)			
♦ Collector:	♦ Collection Date:	♦ Collected Via: <input type="checkbox"/> Venipuncture	
♦ Collection Facility/Lab:	♦ Collection Time:	<input type="checkbox"/> Capillary <input type="checkbox"/> Indwelling Line <input type="checkbox"/> Above shut off IV	
# Serum vial(s) _____ # Plasma vials (p) _____	Referring Lab: Number of tubes sent _____	Samples shipped frozen <input type="checkbox"/>	

SAMPLE TYPE	Clinical History
<input type="checkbox"/> Peripheral Blood Case # _____ <input type="checkbox"/> Bone Marrow Case # _____ <input type="checkbox"/> Formalin-fixed Paraffin-embedded Tissue Case # _____ <input type="checkbox"/> Fresh/Frozen Tissue Case # _____ <input type="checkbox"/> Other _____	

TEST NAME and PURPOSE	TESTING SITE	CODE	Previous Testing		
<input type="checkbox"/> Factor V Leiden and Prothrombin G20210A Mutation Hypercoaguability/Thrombophilia (diagnostic)	HSC	MOL	Other Testing Requirement		
<input type="checkbox"/> B Cell Clonality, Immunoglobulin Gene Arrangement B cell lymphoma (diagnostic)	HSC	HMD			
<input type="checkbox"/> T-Cell Clonality, T Cell Receptor Gene Rearrangement T cell lymphoma (diagnostic)	HSC	HMD			
<input type="checkbox"/> BCR/ABL1 Diagnostic Screen (non-quantitative), t(9;22), Philadelphia Chromosome CML, ALL (diagnostic)	HSC	HMD	<input type="checkbox"/> ABL1 Tyrosine Kinase Inhibitor Resistance Screen CML, ALL (prognostic)	Mayo	HMD
<input type="checkbox"/> BCR/ABL1 Quantitative Monitoring, RQ BCR/ABL1, CML, ALL (follow-up)	HSC	HMD	<input type="checkbox"/> CEBPA Mutation Testing for AML AML (diagnostic)	Mayo	HMD
<input type="checkbox"/> PML/RARA Diagnostic Screen (non-quantitative), t(15;17) APT (diagnostic and follow-up)	HSC	HMD	<input type="checkbox"/> CALR Myeloproliferative Neoplasm (MPN)	Mayo	HMD
<input type="checkbox"/> RUNX/RUNX1T1 (AML1/ETO) Rearrangement, t(8;21) AML (diagnostic)	HSC	HMD	<input type="checkbox"/> C-KIT D816 Point Mutation Analysis Mastocytosis (diagnostic)	Stanford	HMD
<input type="checkbox"/> CBFB/MYH11 Rearrangement, inv(16), AML (diagnostic)	HSC	HMD	<input type="checkbox"/> C-KIT Sequencing Analysis AML (diagnostic)	Stanford	HMD
<input type="checkbox"/> ETV6/RUNX1 (TEL/AML1) Rearrangement, t(12;21) ALL (diagnostic)	HSC	HMD	Prognostic testing requires a funding approval letter from the applicable Regional Health Authority.		
<input type="checkbox"/> JAK2 V617F Mutation (quantitative) Myeloproliferative neoplasm (diagnostic)	HSC	JAK2	Submit samples and completed requisition to:		
<input type="checkbox"/> FLT3/NPM1 for AML AML (diagnostic)	HSC	HMD	Shared Health Hematopathology Molecular Laboratory Health Sciences Centre, MS559 – 820 Sherbrook Street Winnipeg, MB R3A 1R9		