THIS SPACE FOR LAB USE ONLY:
PLACE **LIS** LABEL HERE:

# HEMATOLOGY SERVICES
# BONE MARROW REQUISITION

THIS SPACE FOR LAB USE ONLY:
PLACE **HMD** LABEL HERE:

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** | | PATIENT INFORMATION |
|---|---|---|
| ***Last & Full First Name:** | | *Last/First Name: (per MB Health Card) |
| **Billing Code:** | **Inpatient Location:** | * Date of Birth (dd/mm/yyyy) |
| ***Facility Name/Address** | | *Sex: Female Male |
| **Phone No:** | **Fax No:** | *PHIN: |
| **Critical Results Phone Number:** | | *Specify Province or DND if different |
| **COPY REPORT TO:** ***(If info missing, report may not be sent)*** | | **MRN:** |
| **Last & Full First Name:** | **Fax No:** | Encounter Number: |
| **Facility Name/Address:** | **Phone No:** | Patient Phone Number: |
| **Last & Full First Name:** | **Fax No:** | Patient Address: |
| **Facility Name/Address:** | **Phone No:** | Demographics verified with: ❑ Prov. Health Card ❑ Armband ❑ eChart/CR |

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

| ♦**Collector:** | ♦**Collection Date:** | ♦**Collection Facility/Lab:** | ♦**Collection Time:** |
|---|---|---|---|
| | | | |

**BM #:** _____ ☐ **ASPIRATE(S) [BM]** ☐ **BIOPSY(S) [BMP, BMBX]**

**SPECIMEN SITE:**

☐ ILIAC CREST ☐ L ☐ R ☐ BILATERAL
☐ STERNAL ☐ OTHER Aspirated by (physician): _____

**CLINICAL INFORMATION**: ☐ DIAGNOSTIC ☐ STAGING ☐ FOLLOW-UP

- ☐ CYTOPENIA(S) _____
- ☐ LEUKEMIA -TYPE: _____
- ☐ LYMPHOMA – TYPE: _____
- ☐ MONOCLONAL PEAK - TYPE: _____
- ☐ PLASMA CELL DYSCRASIA – TYPE: _____
- ☐ MYELOPROLIFERATIVE DISORDER – TYPE: _____
- ☐ MYELODYSPLASIA _____
- ☐ OTHER: _____
- ☐ CLINICAL COMMENTS: _____

_____

_____

**THERAPY:** ☐ **NONE**

- ☐ GCSF (CYTOKINES) _____
- ☐ BMT – TYPE: _____
- ☐ TRIAL / STUDY: _____
- ☐ ANTIBODY THERAPY _____
- ☐ CHEMOTHERAPY: _____
- ☐ OTHER: _____

**ANCILLARY STUDIES** (tubes collected) *Subject to triage by a Hematopathologist.* ☐ **NONE**

- ☐ MOLECULAR STUDIES: _____
- ☐ FLOW CYTOMETRY: _____
- ☐ CYTOGENETICS: _____
- ☐ OTHER: _____

**SPECIAL CLINICAL REQUESTS**: _____

_____

THIS SPACE FOR LAB USE ONLY:
PLACE **LIS** LABEL HERE:

# HEMATOLOGY SERVICES

# BONE MARROW REQUISITION

THIS SPACE FOR LAB USE ONLY:
PLACE AP LABEL HERE:

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** | | PATIENT INFORMATION |
|---|---|---|
| ***Last & Full First Name:** | | *Last/First Name: (per MB Health Card) |
| **Billing Code:** | **Inpatient Location:** | * Date of Birth (dd/mm/yyyy) |
| ***Facility Name/Address** | | *Sex: Female Male |
| **Phone No:** | **Fax No:** | *PHIN: |
| **Critical Results Phone Number:** | | *Specify Province or DND if different |
| **COPY REPORT TO:** ***(If info missing, report may not be sent)*** | | **MRN:** |
| **Last & Full First Name:** | **Fax No:** | Encounter Number: |
| **Facility Name/Address:** | **Phone No:** | Patient Phone Number: |
| **Last & Full First Name:** | **Fax No:** | Patient Address: |
| **Facility Name/Address:** | **Phone No:** | Demographics verified with: ❑ Prov. Health Card ❑ Armband ❑ eChart/CR |

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

| ♦**Collector:** | ♦**Collection Date:** | ♦**Collection Facility/Lab:** | ♦**Collection Time:** |
|---|---|---|---|
| | | | |

**BM #:** _____ ☐ **ASPIRATE(S) [BM]** ☐ **BIOPSY(S) [BMP, BMBX]**

**SPECIMEN SITE:**

☐ ILIAC CREST ☐ L ☐ R ☐ BILATERAL
☐ STERNAL ☐ OTHER Aspirated by (physician): _____

**CLINICAL INFORMATION**: ☐ DIAGNOSTIC ☐ STAGING ☐ FOLLOW-UP

- ☐ CYTOPENIA(S) _____
- ☐ LEUKEMIA -TYPE: _____
- ☐ LYMPHOMA – TYPE: _____
- ☐ MONOCLONAL PEAK - TYPE: _____
- ☐ PLASMA CELL DYSCRASIA – TYPE: _____
- ☐ MYELOPROLIFERATIVE DISORDER – TYPE: _____
- ☐ MYELODYSPLASIA _____
- ☐ OTHER: _____
- ☐ CLINICAL COMMENTS: _____

_____

_____

**THERAPY:** ☐ **NONE**

- ☐ GCSF (CYTOKINES) _____
- ☐ BMT – TYPE: _____
- ☐ TRIAL / STUDY: _____
- ☐ ANTIBODY THERAPY _____
- ☐ CHEMOTHERAPY: _____
- ☐ OTHER: _____

**ANCILLARY STUDIES** (tubes collected) *Subject to triage by a Hematopathologist.* ☐ **NONE**

- ☐ MOLECULAR STUDIES: _____
- ☐ FLOW CYTOMETRY: _____
- ☐ CYTOGENETICS: _____
- ☐ OTHER: _____

**SPECIAL CLINICAL REQUESTS**: _____

_____