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

DIAGNOSTIC SERVICES MANITOBA
SERVICES DIAGNOSTIC MANITOBA

HEMATOLOGY SERVICES
BONE MARROW REQUISITION

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

LAB USE ONLY:
COLLECTION DATE/TIME: _____

ARRIVAL DATE/TIME: _____
BM #:

☐ **ASPIRATE(S) [BM]** ☐ **BIOPSY(S) [BMAP]**

SPECIMEN SITE:
☐ ILIAC CREST ☐ *L* ☐ *R* ☐ *Bilateral*
☐ STERNAL
☐ OTHER _____

Authorized by: _____

Aspirated by (Physician)**:** _____

COPY TO: _____

Address must be provided: _____

PATIENT DEMOGRAPHICS (or use addressograph):

Name Phone

PHIN
(Specify Province if not MB)

Hospital Chart #

DOB

Outpatient Address

Outpatient Telephone #

Physician

Physician Emergency Contact No.

Facility/Location

Critical result phone #:

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 (CYOTKINES): _____
- ☐ 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: _____