



London Laboratory Services Group

REGIONAL CYTOGENETICS LABORATORY REQUISITION

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PIN: UNIT: ROOM:
NAME: LAST FIRST
ADDRESS:
SEX: BIRTHDATE: YYY/MM/DD AGE:
OHC#:
PHYSICIAN:

SAMPLE MUST BE LABELLED CORRECTLY

1. TEST REQUESTED

- Chromosome Karyotype
Cells for dispatch to:
FISH (specify probe):
Other:

2. SPECIMEN TYPE

Bone Marrow and Blood should be collected in sterile Sodium Heparin (NaHep) >1-2 mL
DO NOT FREEZE, CENTRIFUGE, SEPARATE OR PLACE DIRECTLY ON ICE PACK.

- Blood (NaHep) Blood in RPMI
Bone Marrow (NaHep)
Amniotic Fluid Gestational age:
Chorionic Villi Gestational age:
Skin Biopsy (HBSS) (specify site):
POC / Fetal Tissue (HBSS)
Specify source:
Lymph Node (RPMI) (specify source):
Solid Tumour (RPMI) (specify source):
Other:

3. CLINICAL INDICATIONS (specimen will not be processed without history)

CONSTITUTIONAL CYTOGENETICS

- MSS (+) (specify):
>3.5 mm NT Measurement
Trisomy (specify):
Turner Syndrome Amenorrhea
Short Stature
Klinefelter Syndrome
Ambiguous Genitalia
Developmental Delay Mental Retardation
Dysmorphic Features Congenital Malformation
Behavioural Problems Failure to Thrive
Microdeletion Syndrome (specify):
≥ 3 Miscarriages Infertility
Stillbirth Neonatal Death
Family study of (specify):
Breakage Syndrome (specify):
Other (specify):

ONCOLOGY CYTOGENETICS

- CML (Philadelphia chromosome)
AML
ALL
CLL
Myelodysplastic Syndrome
Myeloma
Lymphoma (specify):
Paraffin Embedded Tissue (include H&E)
Specify site:
Other (specify):
Post Bone Marrow Transplant
Sex of Donor: Male Female

FAILURE TO COMPLETE REQUISITION WILL RESULT IN DELAYS

Referring Physician: Additional Copies:
Hospital / Lab:
Address:
Telephone: Fax:
Date Specimen Collected (YYYY/MM/DD): Time (HH/MM):
Date Specimen Sent (YYYY/MM/DD): Time (HH/MM):
Requisition Completed by: