



REGIONAL CYTOGENETICS LABORATORY REQUISITION

2 North, West Wing, South Street Hospital
375 South Street, London, Ontario
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Facsimile: (519) 667-6720

PIN _____ UNIT: _____ ROOM: _____
NAME: _____ LAST _____ FIRST _____
ADDRESS: _____
SEX _____ BIRTHDATE: _____ YYYY/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)
- Bone Marrow (NaHep)
- Amniotic Fluid Gestational age: _____
- Chorionic Villi Gestational age: _____
- Skin Biopsy (HBSS) Specify site: _____
- POC / Fetal Tissue (HBSS)
Specify source: _____
- Lymph Node (RPML) Source: _____
- Solid Tumour (RPML) Source: _____
- Other: _____

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

ROUTINE CYTOGENETICS

- MSS (+) (specify): _____
- >3.5 mm NT Measurement
- Trisomy (specify): _____
- Turner Syndrome or Amenorrhea
- Short Stature
- Klinefelter Syndrome
- Ambiguous Genitalia
- Developmental Delay / Dysmorphic Features
- Multiple Malformations
- Microdeletion Syndrome (specify): _____
- >3 Pregnancy Losses / Infertility
- Stillbirth
- Family study of: _____

ONCOLOGY CYTOGENETICS

- CML (Philadelphia chromosome)
- AML / ALL / CLL
- Myelodysplastic Syndrome
- Myeloma
- Lymphoma (specify): _____
- Cancer (specify): _____
- Paraffin Embedded Tissue:
Specify site: _____
- Other: _____
- 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: _____