



**Department of Paediatric Laboratory Medicine
Division of Haematopathology**

Bone Marrow Peripheral Blood

Body Fluid (please specify) _____

Requisition filled by (please print) _____ Ordering physician/NP signature _____

Collection date/time _____

Site of BM Aspiration: Iliac Crest R L Other Trephine Biopsy: Y N

Name _____
HSC# _____
DOB _____
Sex M F Ward _____
Responsible Physician _____

SPECIMEN COLLECTION & DELIVERY

Morphology 6-12 slides Rm 3644, Rapid Response Lab (RRL) x4451	Flow Cytometry 2 mL EDTA, Rm 3644 RRL x8288	Molecular 2 mL EDTA Rm 3603 Atrium, x3319	Cytogenetics: Division of Molecular Genetics Rm 3224, Pager: 416-377-9931, tech required to attend. Relocate needle, 2 mL in Na Heparin @ Room Temperature (RT). After hours, store in transport medium @ RT, send to RRL, leave message @ x5207
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INDICATION FOR TESTING

Leukemia New Day 8 Day 15 Day 29 End of therapy ? Relapse Follow up Other

Other malignancy: Type _____ Staging Follow up Other _____

Other information _____

TEST ORDERING

Morphology <input type="checkbox"/> Morphology only <input type="checkbox"/> Differential count <input type="checkbox"/> Iron stain	Flow Cytometry <input type="checkbox"/> Pending morphology <input type="checkbox"/> MRD <input type="checkbox"/> Specific marker _____ <input type="checkbox"/> Follow L&L protocol	Molecular <input type="checkbox"/> Pending morphology <input type="checkbox"/> MRD <input type="checkbox"/> Specific test _____ <input type="checkbox"/> Follow L&L protocol	Cytogenetics Division of Molecular Genetics <input type="checkbox"/> Store if normal morphology <input type="checkbox"/> Karyotype <input type="checkbox"/> Specific test _____ <input type="checkbox"/> Follow L&L protocol
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LABORATORY USE

____ - ____ Date/time received _____ Cytochemistry <input type="checkbox"/> Y <input type="checkbox"/> N _____ Lab director _____	I ____ - ____ Date/time received _____ Blast/abnormal cell % _____ Proceed with test <input type="checkbox"/> Y <input type="checkbox"/> N Lab director _____	Y ____ - ____ Date/time received _____ Proceed with test <input type="checkbox"/> Y <input type="checkbox"/> N _____ Lab director _____	Cytogenetics lab # _____ Date/time received _____ Volume/count _____ Proceed with test <input type="checkbox"/> Y <input type="checkbox"/> N Lab director _____
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