

SEND TO:**Molecular Diagnostic
Laboratory****Room E3-304**Victoria Hospital
Westminster Tower,
800 Commissioners Road East
London Ontario, N6A 4G5
(519) 685-8122**AUTHORIZED SIGNATURE IS REQUIRED
TO PROCEED WITH TESTING**

Patient's Name: _____

Birthdate: yy / mm / dd

Patient's Address:

Health Card #: _____

Comments:

REQUIRED CLINICAL INFORMATION:

Have samples from this individual been sent to a DNA lab before?

- Yes
 No

 Is this individual in treatment?:_

- New Diagnosis
 Gleevac
 Other Rx.: _____
 BMT: _____
 Start date: yy / mm / dd

 Clinical Condition: _____ White Blood Cell Count: _____**TEST REQUESTED:**

- BCR-ABL Q-PCR (CML)
 JAK2 mutation
 Bank RNA/Research
Other:

If sequencing is required please contact
the laboratory**SAMPLE COLLECTION:** Date Drawn: yy / mm / dd

- EDTA blood (lavender top) 15 cc room temp
 Bone marrow (lavender top) 5-10 cc room temp

SEE WEB SITE FOR MORE INFORMATION:*www.lhsc.on.ca/cgi-bin/view_labtest.pl***AUTHORIZED SIGNATURE:** _____Ordering Physician :
(name, address)**FOR SAMPLE REQUIREMENTS SEE:** <http://www.lhsc.on.ca/lab/molegen/index.htm>For Genetics Requisition please go to <http://www.lhsc.on.ca/lab/molegen/index.htm>