Requisition for Heme Oncology Testing

Reason for Referral:

☐ Diagnostic Testing ☐ Disease Monitoring (MRD)*

Current Rx: _____

Current WBC count for specimen collected: _____

Clinical presentaiton: _____

_____

_____

Patient Information:

Name: _____

Birthdate: *(YY/MM/DD)* _____

Address: _____

Sex: ☐ Male ☐ Female

Health card number: _____

Test Request:

Diagnostic Testing:

☐ Heme-onc NGS Sequence/fusion panel

When choosing NGS panel do not select targeted assays as they are included in the panel

☐ Expedited testing required

Targeted Assays:

☐ CEBPA mutation
☐ Chronic Myelogenous Leukemia (BCR-ABL p210) fusion
☐ BCR-ABL p190 fusion
☐ ETV6-RUNX1 fusion
☐ PML-RARA fusion
☐ RUNX1-RUNX1T1 fusion
☐ TCF3-PBX1 fusion
☐ CALR mutation
☐ FLT3 D835 & ITD mutation
☐ MPL mutation
☐ NPM1 mutation
☐ JAK2 V617F

Sample Collection:

Date drawn: *(YYYY/MM/DD)* _____

☐ EDTA blood (lavender top)(min. 2ml at room temp)
☐ EDTA bone marrow (lavender top)(min. 2ml at room temp)

Lab Use Only:

Received date:

_____

Notes:

_____

_____

_____

_____

AUTHORIZED SIGNATURE IS REQUIRED

Referring Physician:

Physician name (print): _____

Signature: _____

Address: _____

Telephone: _____ Fax: _____

E-mail address: _____

CC report to:

Physician name: _____

Address: _____

Telephone: _____ Fax: _____

MOLECULAR GENETICS LABORATORY
Victoria Hospital, Room B10-123A
800 Commissioners Rd E.
London, Ontario | N6A 5W9

Ph: 519-685-8500 x71560 | Fax: 519-858-1063

London Health Sciences Centre
St. Joseph's Health Care London
Pathology and Laboratory Medicine