

PHN / Healthcare Number		Molecular Pathology Requisition				LABORATORY MEDICINE AND PATHOLOGY Client Response Centre 780-407-7484 CAPITAL HEALTH REGION LABORATORIES DynaLIFE _{dx} DIAGNOSTIC LABORATORY SERVICES			
<input type="checkbox"/> M	Patient Legal Name (Last)	(First)	(Initial)	D O B	DD	MM	YY	Full Name & Location <u>MUST BE PROVIDED</u>	
<input type="checkbox"/> F	Address			City	Prov.	Postal Code			<input type="checkbox"/> Copy to
Chart #		Patient Phone #		Lab #			Name _____		
Ordering Physician / Practitioner				Physician Code		Specimen Event Type			
Ordering Address / Location				Report Location Code		IA	<input type="checkbox"/> AUXILIARY		
Report address if different						IP	<input type="checkbox"/> IN PT		
Date specimen collected		Time (24 h)		Col. Location		EN		<input type="checkbox"/> ENVIRON	
DD MMM YYYY						WCB		<input type="checkbox"/> WORKER'S COMP	
						Molecular Pathology Accession #			

Bill Type

CPL	<input type="checkbox"/>	Alberta Health Care
CCO	<input type="checkbox"/>	Capital Health Company
CO	<input type="checkbox"/>	Company
OT	<input type="checkbox"/>	Out of Prov
XX	<input type="checkbox"/>	Pre-paid
PB	<input type="checkbox"/>	Patient Bill

Co. name _____
 Address _____
 Client # _____

Specimen type blood bone marrow other (*specify*) _____

Clinical history _____

<p>Miscellaneous</p> <p><input type="checkbox"/> Apolipoprotein E genotyping (APOE)</p> <p><input type="checkbox"/> Zygosity testing [Arrange with Dr. Fiona Bamforth at (780)407-7379 or at Fiona.Bamforth@capitalhealth.ca]</p> <p><input type="checkbox"/> Fibroblast culture</p> <p><u>Test Information</u></p> <p>Test(s) Requested _____</p> <p>Storage Only <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p><u>Test(s) Referred Out</u></p> <p>Doctor _____</p> <p>Location _____</p> <p>Specimen Required</p> <p>Pellet <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Viable Fibroblasts <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Number of flasks _____</p>	<p>Lymphoproliferative Disorders</p> <p><input type="checkbox"/> IgH gene rearrangement</p> <p><input type="checkbox"/> t(14;18) <i>IGH@/BCL2</i>[†]</p> <p><input type="checkbox"/> t(11;14) <i>IGH@/CCND1</i>[†]</p> <p><input type="checkbox"/> T cell receptor gamma <i>TRG@</i>[†]</p> <p><input type="checkbox"/> T cell receptor beta <i>TRG@</i>[†]</p> <p><input type="checkbox"/> Other (<i>specify</i>) _____</p> <p>[†] Human Genome Organization Nomenclature</p> <p>Myeloproliferative Disorders/Acute Leukemias</p> <p><input type="checkbox"/> Quantitative t(9;22) <i>BCR/ABL1</i>^{†*}</p> <p><input type="checkbox"/> PGM3 Immunofluorescent assay for t(15;17) – for initial diagnosis only</p> <p><input type="checkbox"/> t(15;17) <i>PML/RARA</i>^{†*}</p> <p><input type="checkbox"/> t(8;21) <i>RUNX1/RUNX1T1</i>^{†*}</p> <p><input type="checkbox"/> <i>JAK2</i> V617F mutational analysis</p> <p><input type="checkbox"/> Other (<i>specify</i>) _____</p> <p>*Note: If a peripheral blood sample is being submitted for these analyses, two EDTA (lavender top) tubes each containing 4 mL of whole blood should be submitted on ice (not frozen). For bone marrow samples, one EDTA (lavender top) tube containing a minimum of 2 mL of bone marrow on ice is required. The Molecular Pathology Laboratory must receive the sample within 24 hours of collection. In addition, please complete the following information:</p> <p>Date of Initial Diagnosis _____</p> <p>Current Treatment and Date of Initiation _____</p> <p>Dosage _____</p> <p>A sterile dedicated sample is required for all Molecular Pathology testing.</p>	<p>Solid Tumors</p> <p><input type="checkbox"/> Microsatellite Instability</p> <p>This individual/family is aware of, and consents to, the test requested. Genetic counseling will be provided, if warranted.</p> <p>Physician Signature _____</p> <p><u>Sample Requirements</u></p> <p>- Representative paraffin blocks from normal (uninvolved) and tumor tissue and respective H&E stained slides</p> <p>- Associated Anatomical Pathology reports</p>
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Lab use only