ALBERTA PRECISION LABORATORIES
Leaders in Laboratory Medicine

Hematology Specialty Requisition

Client Response Centre 780-407-7484

Scanning Label or Accession # *(lab only)*

Patient

PHN Expiry: _____		Date of Birth *(dd-Mon-yyyy)*	
Legal Last Name		Legal First Name	Middle Name
Alternate Identifier	Preferred Name	☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to disclose	Phone
Address		City/Town	Prov / Postal Code

Provider(s)

Authorizing Provider Name *(last, first, middle)*			Copy to Name *(last, first, middle)*	Copy to Name *(last, first, middle)*
Address		Phone	Address	Address
CC Provider ID	CC Submitter ID	Legacy ID	Phone	Phone
Clinic Name			Clinic Name	Clinic Name

Collection

Date *(dd-Mon-yyyy)*	Time *(24 hr)*	Location	Collector ID

SPECIMEN

☐ Blood ☐ Bone Marrow ☐ Other (specify) _____

HISTORY

History and object of examination:

Pertinent drug history:
☐ on Coumadin ☐ on Heparin
☐ on other anticoagulants *(specify)* _____
☐ on G-CSF
Other _____

Physical findings:
Splenomegaly ☐ **No** ☐ **Yes** _____
Hepatomegaly ☐ **No** ☐ **Yes** _____
Lymphadenopathy ☐ **No** ☐ **Yes** _____
Pregnant ☐ **No** ☐ **Yes** _____
Other _____
Recent Transfusions _____

HIT

☐ Heparin-induced thrombocytopenia
Previous heparin exposure (past 3 months)?
☐ No ☐ Yes – if Yes, indicate UNFH or specific LMWH brand
_____
Start Date _____
Stop Date _____
Thrombosis while on heparin? ☐ No ☐ Yes
4T score _____

Special Hematology

☐ Glucose-6-Phosphate Dehydrogenase Panel
☐ Fetomaternal Blood Quantification

Hemoglobinopathy / Malaria Investigation

☐ Hemoglobin F and S Quantitation
☐ Hemoglobinopathy investigation
Ethnic origin _____
☐ Malaria
Travel history _____

Blood Smear & Bone Marrow Aspirate

Examination Required
☐ Smear for Consult Panel
☐ Bone Marrow Exam Panel: aspiration/biopsy (pre-book at 780-407-7484 for UAH patients or through laboratory at other hospitals)

Order any required Microbiology testing on their separate requisition

Complete During Procedure

Site ☐ Left Iliac Crest ☐ Right Iliac Crest
☐ Bilateral Iliac Crests
☐ Sternum
☐ Other *(specify)* _____
Performed by *(name)* _____
Trephine biopsy length _____

Cytogenetics

☐ Karyotype
☐ FISH *(specify)* _____
☐ Other *(specify)* _____

Flow Cytometry – Immunophenotyping

☐ Leukemia/Lymphoma Immunophenotyping
One or more Indication(s) below MUST be selected:
- ☐ Lymphoma / Lymphoproliferative disorder
- ☐ Acute Leukemia
- ☐ Minimal Residual Disease
- ☐ Plasma Cell Neoplasia
- ☐ Pancytopenia (Bone Marrow ONLY)

☐ PNH panel
☐ B Cell Enumeration
☐ T-Cell Subsets CD3/CD4/CD8 Only
☐ Hereditary Spherocytosis
☐ Hereditary Spherocytosis with Osmotic Fragility (Pre-book at 780-407-7484)

Other Tests