ALBERTA PRECISION LABORATORIES
Leaders in Laboratory Medicine

Flow Cytometry - Foothills Medical Centre
1403-29 th Street N.W. Calgary, Alberta T2N 2T9
Tel: 403-944-4765 Fax: 403-270-4135
CLSFlowCytometry@cls.ab.ca

Shaded areas are Required Information

FLOW CYTOMETRY OUT OF PROVINCE REQUISITION

PROVINCE/ STATE	PERSONAL HEALTH NUMBER (PHN)	REGIONAL HEALTH RECORD NUMBER
	–	

ORDERING PHYSICIAN (Apply Dr. Office Stamp Here):

Last Name / Full First Name:

Location/Facility/Address:

Phone Number:

Physician Email:

Copy to:

1. Last Name/ Full First Name: Phone:
   Office Address/Location:

2. Last Name/ Full First Phone:
   Office Address Location

Results to be Fax to: _____

PATIENT LAST NAME	FULL FIRST NAME	MIDDLE NAME

PATIENT ADDRESS	CITY, PROVINCE/STATE	POSTAL CODE/ZIP CODE

CHART NUMBER	GENDER	DATE OF BIRTH	PATIENT PHONE NUMBER
		_ _ _ _ / _ _ _ / _ _ (Y Y Y Y M M M D D)	(_____) _____- _____

ORDERING LOCATION

☐ Canada ☐ U.S.A ☐ OTHER _____

Institution/Lab Name: _____

ENCOUNTER TYPE:	FINANCIAL CLASS:	LABORATORY NAME FOR COMPANY BILL:
Referred in Specimen	Company Bill	ENTER: _____

HEMATOPATHOLOGY ☐ New Diagnosis ☐ Follow-up

CLINICAL INFORMATION

SAMPLE TYPE

LEUK/LOMA PB	☐ Peripheral Blood
LEUK LOMA	☐ Bone Marrow ☐ BAL ☐ CSF mL: _____ ☐ Tissue Site: _____ ☐ Fluid Site: _____ ☐ Other:

LEUKEMIA/LYMPHOMA PANEL

- ☐ Acute Leukemia Panel
- ☐ Lymphoma Screening Panel
- ☐ Pancytopenia/MDS Panel
- ☐ MRD – AML Panel
- ☐ MRD – B-ALL Panel
- ☐ MRD – T-ALL Panel
- ☐ Plasma Cell Dyscrasia Panel
- ☐ ZAP-70: (Previously diagnosed CLL only)

Department Use Only:

- ☐ Add On: HCL Panel
- ☐ Add On: B-NHL Panel
- ☐ Add On: T-NHL Panel

MISCELLANEOUS

B27	☐	HLA-B27
PLDY	☐	DNA Ploidy (Non-Blood or Paraffin Block)
PLDY PB	☐	DNA Ploidy (Peripheral Blood)
PNH	☐	Paroxysmal Nocturnal Hemoglobinuria Panel

ERYTHROCYTES

HS	☐	Hereditary Spherocytosis
FMH PB	☐	Fetomaternal Hemorrhage (Peripheral Blood)

PLATELETS

PLAG	☐	Platelet Surface Markers
POOL	☐	Platelet Storage Pool Deficiency (Monday - Thursday only)
PRET	☐	Platelet Reticulocytes

IMMUNE MONITORING

CD4	☐	CD4 Count (CD3, CD4, CD8)
RITUXIM	☐	CD19 Quantitation

IMMUNODEFICIENCY INVESTIGATION

ALPS	☐	Autoimmune Lymphoproliferative Syndrome Screen
BSUBSETS	☐	B Cell Subsets Panel
BTK	☐	Bruton Tyrosine Kinase Protein Expression
CD57	☐	CD57 Positive NK Cells
CD107A	☐	NK Cell Degranulation (CD107a)
CD127/CD132	☐	SCID Screen
DOCK8	☐	DOCK8 Protein Expression
HLH	☐	Perforin/Granzyme B
ICOS	☐	Inducible Costimulatory Molecule (CD278)
IL12PATHWAY	☐	IL-12Rβ1 (CD212) and pSTAT4*
INFGPATHWAY	☐	INF-γRα (CD119) and pSTAT1*
IDEF	☐	Immunodeficiency Screening Panel
INKT	☐	Invariant NK Cells
LAD	☐	Leukocyte Adhesion Deficiency
LAM	☐	Lymphocyte Activation Markers
LINK	☐	Hyper IgM Syndrome Screen
LRBA	☐	LRBA Protein Expression
MSA	☐	Mitogen Stimulation Assay
NFUN	☐	Neutrophil Function – Oxidative Burst
PSTAT3	☐	Phosphorylated STAT3
PSTAT5	☐	Phosphorylated STAT5*
RTE	☐	Recent Thymic Emigrants
SORT SCID	☐	T Cell Sort for Maternal Engraftment (SCID investigation)
TCR FLOW	☐	TCRvβ Repertoire
TCRABGD	☐	TCRαβ and TCRγδ Subsets
TH17	☐	Th17 Enumeration
TREG	☐	Regulatory T Cells (FoxP3)
TSUBSETS	☐	T Cell Subsets Panel
WASP	☐	Wiskott Aldrich Syndrome Protein Expression
XLP1	☐	SAP Protein Expression
XLP2	☐	XIAP Protein Expression
ZAP70 SCID	☐	ZAP-70 Protein Expression

***Tests Temporarily Unavailable**

ACCESSION NUMBER:

Sample Specifications:

Date Collected: _____
yyyy / mm / dd

Time Collected: _____

Sample Type:
- ◯ PERIPHERAL BLOOD
- ◯ FLUID: _____
- ◯ BONE MARROW ASPIRATE
- ◯ BONE MARROW BIOPSY
- ◯ TISSUE: _____
- ◯ OTHER: _____

Special Instructions:

Clinical Information for Immunodeficiency Investigation:

Suspected Diagnosis: _____

Indication for Testing:
◯ Carrier Screen ◯ Diagnostic ◯ Family History ◯ Other _____

◯ Post HSC Transplant Date: _____
yyyy / mm / dd

History:

Physical Findings:

Family History:

Other Lab Findings:

Billing and Payment Information:

Please check your billing preference below.

◯ **Institutional Billing: (New Client)**

_____
Hospital/Lab Name

_____
Billing Contact Name

_____
Address

_____
City Prov/State Postal/Zip Code

_____
Phone Fax

_____
Email

◯ **Existing Client: Client # _____**

Specimen Shipping Information:

* Overnight shipping via Courier is ***required***.
* Completed test requisition and payment forms must be included with each sample.
* Please refer to our Guide To Services for specific sample collection and handling information at www.albertaprecisionlabs.ca.
* Please package as per courier guidelines to ensure samples arrive safely.
* **Ship Directly To:**
  Flow Cytometry Laboratory
  7th Floor McCaig Tower – Foothills Medical Centre
  1403 – 29th Street NW
  Calgary, Alberta, Canada
  T2N 2T9
* Send requisition including the **Courier and waybill information** to our lab so that we can track your specimen: Fax to 403-270-4135

COURIER	☐ FedEx (recommended) ☐ Purolator ☐ UPS ☐ Other:
WAYBILL #	

Additional Information:

* The lab operates Mon – Fri 7:00am to 8:00pm (MST) and Sat 9:00am to 5:00pm (MST).
* Samples are received and tested during these hours only, unless otherwise stated.
* Please see the Guide to Services for test specific information.

Ordering Checklist:

◯ Completed requisition form (Page 1 & 2)
◯ Completed billing information (Page 2)
◯ Fax number provided for results (Page 1)
◯ Specimen collection requirements met
◯ Specimen appropriately labelled, packaged and ready to ship
◯ Test requisition and waybill information faxed to 403-270-4135

COLLECTION REQUIREMENTS FOR APL FLOW CYTOMETRY TESTING

See APL website at www.albertaprecisionlabs.ca for more detailed information.

TEST ABBREVIATION	COLLECTION REQUIREMENTS
ALPS	1 x 4 mL dark green top sodium heparin. See #2 below.
B27	Pediatric: 1 x 1.8 mL blue top sodium citrate. Adult: 1 x 8.5 mL yellow top ACD-A.
BSUBSETS	1 x 4 mL dark green top sodium heparin. See #2 below.
BTK	Pediatric: 1 x 1.8 mL blue top sodium citrate. Adult: 1 x 8.5 mL yellow top ACD-A.
CD34	1 x 4 mL lavender top EDTA
CD57	1 x 4 mL dark green top sodium heparin.
CD107a	1-2 x 4 mL dark green top sodium heparin only. See #4 below.
CD127/CD132	Pediatric: 1 x 1.8 mL blue top sodium citrate. Adult: 1 x 8.5 mL yellow top ACD-A.
CD4	Pediatric: 1 x 0.5mL lavender top ETDA tube. Adult: 1 x 4 mL lavender top EDTA
DOCK8	1 x 4 mL dark green top sodium heparin
FMH	1 x 4 mL lavender top EDTA
HLH	Pediatric: 1 x 1.8 mL blue top sodium citrate. Adult: 1 x 8.5 mL yellow top ACD-A.
HS	Pediatric: 1 x 1.8 mL blue top sodium citrate **and** 1 x 4mL lavender EDTA. Adult: 1 x 8.5 mL yellow top ACD-A **and** 1 x 4mL lavender EDTA
ICOS	Pediatric: 1 x 4 mL dark green top sodium heparin. Adult: 2 x 4 mL dark green top sodium heparin.
IL12PATHWAY	2 x 4 mL dark green top sodium heparin. See #5 below.
INFGPATHWAY	2 x 4 mL dark green top sodium heparin. See #5 below.
IDEF	Pediatric: 1 x 1.8 mL blue top sodium citrate. See #2 below. Adult: 1 x 8.5 mL yellow top ACD-A.
iNKT	1 x 4 mL dark green top sodium heparin.
LAD	Pediatric: 1 x 1.8 mL blue top sodium citrate. Adult: 1 x 8.5 mL yellow top ACD-A.
LAM	Pediatric: 1 x 4 mL dark green top sodium heparin. Adult: 2 x 4 mL dark green top sodium heparin.
LEUK LOMA	Blood: Pediatric: 1 x 1.8 mL blue top sodium citrate. Adult: 1 x 8.5 mL yellow top ACD-A. All other specimen types: refer to APL Guide to Lab Services for Leukemia/Lymphoma Panels collection guidelines
LINK	Pediatric: 1 x 4 mL dark green top sodium heparin. Adult: 2 x 4 mL dark green top sodium heparin.
LRBA	1 x 4 mL dark green top sodium heparin.
MSA	2 x 4 mL dark green top sodium heparin. See #5 below. Collect Wednesday only.
NFUN	Pediatric: 1 x 1.8 mL blue top sodium citrate. Adult: 1 x 8.5 mL yellow top ACD-A.
PLAG	Pediatric: 1 x 1.8 mL blue top sodium citrate. Adult: 1 x 8.5 mL yellow top ACD-A.
PLDY	Paraffin embedded tissue: 3x50um sections. Blood: Pediatric: 1 x 1.8 mL blue top sodium citrate. Adult: 1 x 8.5 mL yellow top ACD-A.
POOL	1 x 8.5 mL yellow top ACD-A or 1 4.5 mL blue top sodium citrate. Testing must be performed within 8 hours of collection
PRET	Pediatric: 1 x 1.8 mL blue top sodium citrate. See #2 below. Adult: 1 x 8.5 mL yellow top ACD-A.
pSTAT3	Pediatric: 1 x 4 mL dark green top sodium heparin. Adult: 2 x 4 mL dark green top sodium heparin.
pSTAT5	Pediatric: 1 x 4 mL dark green top sodium heparin. Adult: 2 x 4 mL dark green top sodium heparin.
RITUXIM	1 x 4 mL lavender top EDTA. See #2 below.
RTE	1 x 4 mL dark green top sodium heparin.
SORT SCID	Pediatric: 1 x 1.8 mL blue top sodium citrate. Adult: 1 x 8.5 mL yellow top ACD-A. **Parent's samples should accompany the patient sample**
TCRABGD	1 x 4 mL dark green top sodium heparin
TCR vbeta	Pediatric: 1 x 1.8 mL blue top sodium citrate. Adult: 1 x 8.5 mL yellow top ACD-A.
Th17	1 x 4 mL dark green top sodium heparin.
TREG	Pediatric: 1 x 0.5mL EDTA microcollection container Adult: 1 x 4 mL lavender top EDTA. See #2 below.
TSUBSETS	1 x 4 mL dark green top sodium heparin. See #2 below.
WASP	1 x 4 mL dark green top sodium heparin.
XLP1	Pediatric: 1 x 1.8 mL blue top sodium citrate. Adult: 1 x 8.5 mL yellow top ACD-A.
XLP2	Pediatric: 1 x 1.8 mL blue top sodium citrate. Adult: 1 x 8.5 mL yellow top ACD-A.
ZAP70 SCID	Pediatric: 1 x 1.8 mL blue top sodium citrate. Adult: 1 x 8.5 mL yellow top ACD-A.

SPECIMEN HANDLING NOTES

1. A partial draw in an ACD-A tube is not recommended.
2. A CBC/DIFF must also be collected and results faxed to 403-270-4135.
3. **Out of Province:** ship at room temperature by overnight courier. Fax waybill to 403-270-4135. Do not collect/ship on Fridays or the day prior to a STAT holiday.
4. Must be received for testing within 24h of collection. Ship a normal sample with the patient sample as a control.
5. Do not refrigerate.