



Cytogenetics Accession Number _____

MOLECULAR CYTOGENETICS

Bone Marrow or Peripheral Blood Chromosome Analysis and / or Fluorescence In-Situ Hybridization

Royal Columbian Hospital Phone (604) 520-4484
330 E Columbia St. Fax (604) 520-4149
New Westminster, BC V3L 3W7

Patient name: _____
Last First

Date of Birth: _____ Sex: M F
DD/MM/YYYY

PHN: _____

Insurance: _____
Self pay, Out of Prov., WCB, RCMP, Veterans, and Refugee etc.

Ordering Physician: _____

Physician MSP Number: _____

Patient Address: _____ City: _____

Province/State: _____ Country: _____ Postal Code: _____ Phone: _____

Additional copies to: _____
Name & MSP number Name & MSP number Name & MSP number

1. ALL Patient Demographics must be printed legibly and completed in full.
 2. Failure to provide Clinical Data may result in a delayed report.
 3. All Non Canadian Residents must sign a FHA waiver form. The signed and witnessed form must be attached to the requisition when specimen submitted.
- [Molecular Cytogenetics Specimen Collection and Submission](#)

Procuring physician: _____ Collection date: _____ Collection time: _____
Name & MSP number DD/MM/YYYY HH:MM

Bone Marrow Peripheral blood

Clinical Data:

Provisional Diagnosis:

ALL AML CLL CML Burkitt's

Other (specify) _____

Physician signature or stamp: _____

LAB USE ONLY:

Date received: _____ Date incubated: _____

Sample: Bone marrow _____ RPMI tubes, volume _____ mL Blood _____ Na heparin, volume _____ mL

Cytogeneticist comment: _____

Prelim diagnosis called to: _____ Date: _____