fraserhealth Better health. Best in health care.

Reset Form

Cytogenetics Accession Number

_____

Patient name: _____
Last First

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

PHN: _____

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

Ordering Physician: _____

Physician MSP 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 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/MMM/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: _____