



fraserhealth

# Bone Marrow Requisition

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ M F

PHN: \_\_\_\_\_

Form ID: LBXX106852A

Rev: Apr 04, 2017

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PATIENT DEMOGRAPHICS: (or place the Addressograph Label above)		LAB USE ONLY
<input type="checkbox"/> Inpatient/ Ward _____ <input type="checkbox"/> Outpatient Patient Address: _____ City: _____ Province/State: _____ Country: _____ Postal Code: _____ Phone: _____ Ordering Physician: _____ MSP: _____ Copies To: _____ MSP: _____ Copies To: _____ MSP: _____		<b>Date and Time of Procedure:</b> _____ <input type="checkbox"/> Patient Notified <b>To be performed by (Optional):</b> _____ <b>Pathologist Approval:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes: _____ <small>(Pathologist Signature) (Date: dd/mmm/yyyy)</small>
<b>MEDICAL HISTORY AND PHYSICAL FINDINGS:</b>		
Pt on anticoagulants: <input type="checkbox"/> No <input type="checkbox"/> Yes Type: _____ Diagnosis/indications: _____ Relevant History: <input type="checkbox"/> Splenomegaly <input type="checkbox"/> Hepatomegaly <input type="checkbox"/> Lymphadenopathy Post RBC Transfusion: <input type="checkbox"/> No <input type="checkbox"/> Yes Number of Units: _____ Date: _____ Previous Marrow: <input type="checkbox"/> No <input type="checkbox"/> Yes Date of Previous Marrow: _____		
<b>ANCILLARY TESTS REQUESTED BY PHYSICIAN:</b>		
<input type="checkbox"/> Cytogenetics (RCH) <input type="checkbox"/> CFU (TFL) <input type="checkbox"/> BCR-ABL CML- Peripheral Blood (RCH) <input type="checkbox"/> PNH - Peripheral Blood (SMH) <input type="checkbox"/> Erythropoietin Level (TFL) <input type="checkbox"/> FISH (RCH) -Specify: _____ <b>Flow Cytometry:</b> <input type="checkbox"/> Myeloid (VGH) <input type="checkbox"/> Lymphoid (BCCA) <input type="checkbox"/> Myeloma (VGH) Please complete <a href="#">BCCA Flow Cytometry Requisition</a> and submit with BM request. <b>Genetic Testing:</b> <input type="checkbox"/> Myeloid Panel Genetic Testing - (BCCA) <input type="checkbox"/> Lymphoid Genetic Testing - (BCCA) Please complete <a href="#">BCCA Cancer Genetics Laboratory Requisition</a> and submit with BM request. <input checked="" type="checkbox"/> CBC & Retic <input checked="" type="checkbox"/> BME		
<b>ADDITIONAL TESTS AND SPECIAL INSTRUCTIONS:</b>		
<hr/>		
LAB USE ONLY		
<b>COLLECTION INFORMATION:</b>		
<b>BM Site:</b> <input type="checkbox"/> Posterior Iliac Crest <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Anterior Iliac Crest <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Sternum <input type="checkbox"/> Other: _____		Collection Date & Time: _____ Performed By: _____ Number of Slides: _____ Length of Core Biopsy: _____ mm
<b>Flow Cytometry</b> <input type="checkbox"/> VGH <input type="checkbox"/> BCCA <input type="checkbox"/> Collected <input type="checkbox"/> Sent <b>Sample Type:</b> <input type="checkbox"/> PB <input type="checkbox"/> BM <b>Hematopathologist:</b> _____	<b>Genetics Testing</b> <input type="checkbox"/> Collected <input type="checkbox"/> Sent <b>Sample Type:</b> <input type="checkbox"/> BM <b>Hematopathologist:</b> _____	<b>Cytogenetics</b> <input type="checkbox"/> Collected <input type="checkbox"/> Sent <b>Sample Type:</b> <input type="checkbox"/> PB <input type="checkbox"/> BM <b>Hematopathologist:</b> _____
Notified: <input type="checkbox"/> <b>VGH Flow Cytometry</b> 604-875-4111 Ext. 62609 <input type="checkbox"/> <b>BCCA Flow Cytometry</b> 604-877-6000 Ext. 672085	Notified: <input type="checkbox"/> <b>BCCA -Genetics Lab</b> 604-877-6000 Ext. 672094	Notified: <input type="checkbox"/> <b>RCH Cytogenetics</b> 604-520-4484

# BONE MARROW REQUISITION

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## **Abbotsford Regional Hospital and Cancer Centre:**

Special Hematology Laboratory:

Phone: 604-854-2113

Bone Marrow Bookings:

Phone: 604-851-4700 Ext. 646545

Fax: 604-851-4858

## **Burnaby Hospital:**

Hematology Lab Bone Marrow Bookings:

Phone: 604-412-6253

Fax: 604-431-2806

## **Royal Columbian Hospital:**

Hematology Laboratory:

Hematopathology consult: 604-520-4323

Bone Marrow Bookings:

Phone: 604-520-4300

Fax: 604-520-4864

## **Surrey Memorial Hospital:**

Hematology Laboratory:

Phone: 604-585-5666 Ext. 774801

Fax: 604-587-3861