fraserhealth

Bone Marrow Requisition

Patient Name:

Date of Birth: M ☐ F ☐

PHN:

Form ID: LBXX106852A Rev: Apr 04, 2017 Page: 1 of 1

PATIENT DEMOGRAPHICS: (or place the Addressograph Label above)

☐ **Inpatient/ Ward** _____ ☐ **Outpatient**

Patient Address: _____ **City:** _____

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

Ordering Physician: _____ **MSP:** _____

Copies To: _____ **MSP:** _____

Copies To: _____ **MSP:** _____

LAB USE ONLY

Date and Time of Procedure: _____

☐ **Patient Notified**

To be performed by (Optional): _____

Pathologist Approval:

☐ No

☐ Yes: _____ _____
(Pathologist Signature) *(Date: dd/mmm/yyyy)*

MEDICAL HISTORY AND PHYSICAL FINDINGS:

Pt on anticoagulants: ☐ No ☐ Yes Type: _____

Diagnosis/indications: _____

Relevant History: ☐ Splenomegaly ☐ Hepatomegaly ☐ Lymphadenopathy

Post RBC Transfusion: ☐ No ☐ Yes **Number of Units:** _____ **Date:** _____

Previous Marrow: ☐ No ☐ Yes **Date of Previous Marrow:** _____

ANCILLARY TESTS REQUESTED BY PHYSICIAN:

☐ Cytogenetics (RCH)
☐ BCR-ABL CML- Peripheral Blood (RCH)
☐ Erythropoietin Level (TFL)
☐ CFU (TFL)
☐ PNH - Peripheral Blood (SMH)
☐ FISH (RCH) -Specify: _____

Flow Cytometry: ☐ Myeloid (VGH) ☐ Lymphoid (BCCA) ☐ Myeloma (VGH)
Please complete ***BCCA Flow Cytometry Requisition*** and submit with BM request.

Genetic Testing: ☐ Myeloid Panel Genetic Testing - (BCCA) ☐ Lymphoid Genetic Testing - (BCCA)
Please complete ***BCCA Cancer Genetics Laboratory Requisition*** and submit with BM request.

☐ CBC & Retic ☐ BME

ADDITIONAL TESTS AND SPECIAL INSTRUCTIONS:

_____

LAB USE ONLY

COLLECTION INFORMATION:

BM Site: ☐ Posterior Iliac Crest ☐ Right ☐ Left
☐ Anterior Iliac Crest ☐ Right ☐ Left
☐ Sternum
☐ Other: _____

Collection Date &Time: _____
Performed By: _____
Number of Slides: _____
Length of Core Biopsy: _____ mm

Flow Cytometry ☐ VGH ☐ BCCA
☐ Collected ☐ Sent
Sample Type: ☐ PB ☐ BM
Hematopathologist:

Notified: ☐ **VGH Flow Cytometry** 604-875-4111 Ext. 62609
☐ **BCCA Flow Cytometry** 604-877-6000 Ext. 672085

Genetics Testing
☐ Collected ☐ Sent
Sample Type: ☐ BM
Hematopathologist:

Notified: ☐ **BCCA -Genetics Lab** 604-877-6000 Ext. 672094

Cytogenetics
☐ Collected ☐ Sent
Sample Type: ☐ PB ☐ BM
Hematopathologist:

Notified: ☐ **RCH Cytogenetics** 604-520-4484

This form is not to be retained on the permanent health record

BONE MARROW REQUISITION

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