



fraserhealth

Bone Marrow Requisition

Patient Name: _____

Date of Birth: _____

M F

PHN: _____

Form ID: LBXX106852B

Rev: May 29, 2019

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PATIENT DEMOGRAPHICS: (or place the Addressograph Label above)		LAB USE ONLY
<input type="checkbox"/> Inpatient/ Ward _____ <input type="checkbox"/> Outpatient Ordering Physician: _____ MSP: _____ Copies To: _____ MSP: _____ Copies To: _____ MSP: _____		Date and Time of Procedure: _____ <input type="checkbox"/> Patient Notified Pathologist Approval: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Urgent _____ <i>(Pathologist Signature) (Date: dd/mmm/yyyy)</i>
MEDICAL HISTORY AND PHYSICAL FINDINGS:		
Pt on anticoagulants: <input type="checkbox"/> No <input type="checkbox"/> Yes Type: _____ Diagnosis/indications: _____		
Allergies: <input type="checkbox"/> Latex <input type="checkbox"/> Lidocaine Relevant History: <input type="checkbox"/> Splenomegaly <input type="checkbox"/> Hepatomegaly <input type="checkbox"/> Lymphadenopathy Previous Marrow: <input type="checkbox"/> No <input type="checkbox"/> Yes Date of Previous Marrow: _____		
ANCILLARY TESTS REQUESTED BY PHYSICIAN:		
Bone Marrow: <input type="checkbox"/> BME <input type="checkbox"/> Cytogenetics/FISH (RCH) - Specify: _____ <i>(Please complete Cytogenetics Cancer Studies Requisition and submit with BM request)</i> <input type="checkbox"/> CFU (TFL)		Peripheral Blood: <input checked="" type="checkbox"/> CBC & Retic <input type="checkbox"/> PNH - Peripheral Blood (SMH) <input type="checkbox"/> Erythropoietin Level (TFL) <input type="checkbox"/> JAK2
Flow Cytometry: <input type="checkbox"/> Myeloid (VGH) <input type="checkbox"/> Lymphoid (BCCA) <input type="checkbox"/> Myeloma (VGH) <i>(Please complete Flow Cytometry Requisition and submit with BM request)</i>		
Genetic Testing: <input type="checkbox"/> Myeloid Panel Genetic Testing <input type="checkbox"/> Lymphoid Genetic Testing <i>(Please complete Cancer Genetics Laboratory Requisition and submit with BM request)</i>		
ADDITIONAL TESTS AND SPECIAL INSTRUCTIONS:		

LAB USE ONLY		
COLLECTION INFORMATION:		
BM Site: <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
Flow Cytometry <input type="checkbox"/> VGH <input type="checkbox"/> BCCA <input type="checkbox"/> Collected <input type="checkbox"/> Sent <input type="checkbox"/> Cancelled Sample Type: <input type="checkbox"/> PB <input type="checkbox"/> BM Hematopathologist: _____	Genetics Testing <input type="checkbox"/> For DNA Extraction <input type="checkbox"/> Collected <input type="checkbox"/> Sent <input type="checkbox"/> Cancelled Sample Type: <input type="checkbox"/> BM Hematopathologist: _____	Cytogenetics <input type="checkbox"/> Collected <input type="checkbox"/> Sent <input type="checkbox"/> Cancelled Sample Type: <input type="checkbox"/> PB <input type="checkbox"/> BM Hematopathologist: _____
Notified: <input type="checkbox"/> VGH Flow Cytometry 604-875-4111 Ext. 62609 <input type="checkbox"/> BCCA Flow Cytometry 604-877-6000 Ext. 672085	Notified: <input type="checkbox"/> BCCA -Genetics Lab 604-877-6000 Ext. 672094	Notified: <input type="checkbox"/> RCH Cytogenetics 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