fraserhealth

Bone Marrow Requisition

Form ID: LBXX106852C Rev: Feb 21, 2020 Page: 1 of 1

PATIENT DEMOGRAPHICS: (or place the Addressograph Label above)

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

Ordering Physician: _____ **MSP:** _____

Copies To: _____ **MSP:** _____

Copies To: _____ **MSP:** _____

LAB USE ONLY

Date and Time of Procedure: _____

☐ **Patient Notified**

Pathologist Approval:

☐ No ☐ Yes ☐ Urgent

_____ _____

(Pathologist Signature) *(Date: dd/mmm/yyyy)*

MEDICAL HISTORY AND PHYSICAL FINDINGS:

Pt on anticoagulants: ☐ No ☐ Yes Type: _____

Diagnosis/indications: _____

Allergies: ☐ Latex ☐ Lidocaine

Relevant History: ☐ Splenomegaly ☐ Hepatomegaly ☐ Lymphadenopathy

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

ANCILLARY TESTS REQUESTED BY PHYSICIAN:

Bone Marrow:

☐ BME

☐ Cytogenetics/FISH (RCH) - Specify: _____

(Please complete *Cytogenetics Cancer Studies Requisition* and submit with BM request)

☐ CFU (TFL)

Peripheral Blood:

☑ CBC & Retic

☐ PNH - Peripheral Blood (SMH)

☐ Erythropoietin Level (TFL)

☐ JAK2

Flow Cytometry: ☐ Lymphoid (SMH) ☐ Hairy Cell (SMH) ☐ Myeloma (VGH) ☐ Myeloid (VGH)

(VGH Testing: Please complete *Flow Cytometry Requisition* and submit with BM request)

Genetic Testing: ☐ Myeloid Panel Genetic Testing ☐ Lymphoid Genetic Testing

(Please complete *Cancer Genetics Laboratory Requisition* and submit with BM request)

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 ☐ SMH

☐ Collected ☐ Sent ☐ Cancelled

Sample Type: ☐ PB ☐ BM

Hematopathologist:

_____

Notified: ☐ **VGH Flow Cytometry** 604-875-4111 Ext. 62609

☐ **SMH Flow Cytometry** 604-585-5666 Ext.774669

Genetics Testing

☐ For DNA Extraction

☐ Collected ☐ Sent ☐ Cancelled

Sample Type: ☐ BM

Hematopathologist:

_____

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

Cytogenetics

☐ Collected ☐ Sent ☐ Cancelled

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