



Molecular Cytogenetics Cancer Studies Requisition

Royal Columbian Hospital
Molecular Cytogenetics Laboratory Rm. B180
330 East Columbia Street, New Westminister, BC, V3L 3W7
Tel: (604) 520-4484 Fax: (604) 520-4149

Laboratory Use Only
Accessioning Number
Received Date

Patient Information

Last Name _____
Date of Birth (DD/MM/YY) _____
Gender: M F
Patient Address _____

First Name _____
PHN _____
Patient Telephone # _____

Physician Information

Ordering Physician (Name and Billing #) _____
Additional Reports to: (Name and Billing #) _____

Note: All Non-Canadian Residents must submit a signed and witnessed FHA waiver form. Please attach waiver to the lab requisition.
Further Collection and waiver form: Molecular Cytogenetics Specimen Collection and Submission

Diagnosis and Clinical History

Please Specify:
Previous Cytogenetic Analysis: Yes No Cytogenetics Laboratory and Accessioning # _____

Peripheral Blood: (Note: Blood may be processed for Karyotype if circulating blasts are >10%)

- CLL** Stimulated Karyotype and FISH (MYB, ATM, CEN 12, 13q14.2, IGH, TP53) – 3 mL in Sodium Heparin to RCH
 IGHV Mutational Status Test – 2 X 5 mL in EDTA, sent to VGH
- CML** Diagnostic FISH: BCR/ABL1 t(9;22) – 3 mL in Sodium Heparin to RCH
 MRD Baseline MRD Monitor Kinase Domain – 4 X 6 mL in EDTA, sent to BC Cancer
- APL** Diagnostic FISH: PML/RARA t(15;17) – 3 mL in Sodium Heparin to RCH
 MRD Baseline MRD Monitor – 4 X 6 mL in EDTA, sent to BC Cancer
- Eosinophilia** Diagnostic FISH: FIP1L1/CHIC2/PDGFRA, PDGFRB, FGFR1, JAK2 – 3 mL in Sodium Heparin to RCH

Bone Marrow: This procedure requires pre-booking with the Hematology Department of the collecting hospital
Collection Criteria: **2 X 2-4 mL bone marrow in transport media** (available from RCH Molecular Cytogenetics Laboratory)

Procuring Physician: _____ Collection Date: _____

Acute Myeloid Leukemia (AML) Other, specify _____	<input type="checkbox"/> Karyotype FISH (specify): <input type="checkbox"/> RUNX1/RUNX1T1 t(8;21) <input type="checkbox"/> CFBF rearrangement inv(16) <input type="checkbox"/> BCR/ABL1 t(9;22) <input type="checkbox"/> KMT2A	Chronic Lymphocytic Leukemia (CLL) Lymphoma Burkitt DLBC / Double Hit / Triple Hit Mantle Cell Follicular	<input type="checkbox"/> Stimulated Karyotype <input type="checkbox"/> FISH: MYB, ATM, CEN 12, 13q14.2, IGH, TP53 <input type="checkbox"/> Karyotype FISH (Specify): <input type="checkbox"/> MYC, MYC/IGH <input type="checkbox"/> MYC, MYC/IGH, IGH/BCL2, BCL6 <input type="checkbox"/> CCND1/IGH t(11;14) <input type="checkbox"/> IGH/BCL2 t(14;18)
	Acute Promyelocytic Leukemia (APL) <input type="checkbox"/> Karyotype <input type="checkbox"/> FISH: PML/RARA t(15;17)	Lymphoid and Myeloid Neoplasm with Eosinophilia	<input type="checkbox"/> Karyotype <input type="checkbox"/> FISH: FIP1L1/CHIC2/PDGFRA
Acute Lymphoblastic Leukemia (ALL) Other, specify _____	<input type="checkbox"/> Karyotype <input type="checkbox"/> FISH: BCR/ABL1 t(9;22)	Multiple Myeloma (Bone Marrow only) Myelodysplastic Syndrome	<input type="checkbox"/> Karyotype <input type="checkbox"/> FISH: CDKN2C/CKS1B (1p/1q), TP53, FGFR3/IGH, CCND1/IGH, IGH/MAF <input type="checkbox"/> Karyotype
Chronic Myelogenous Leukemia (CML) <input type="checkbox"/> Myeloproliferative Neoplasm <input type="checkbox"/>	<input type="checkbox"/> Karyotype <input type="checkbox"/> FISH: BCR/ABL1 t(9;22)		

Ordering Physician Signature (Required) _____ Date (DD/MM/YY) _____