

CANCER GENETICS LABORATORY



BRITISH COLUMBIA CANCER AGENCY
 DEPT. OF PATHOLOGY AND LABORATORY MEDICINE
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ADDRESSOGRAPH OR PATIENT LABEL

LYMPHOID TESTING REQUISITION

See website www.cancergeneticslab.ca for current Myeloid, Lymphoid, Solid Tumor and Hereditary test information and requisitions

PATIENT INFORMATION				REQUESTING PHYSICIAN				
Last Name		First and Middle Names		Name		MSC		
Date of Birth dd/mmm/yyyy	Sex <input type="checkbox"/> M <input type="checkbox"/> F	PHN	BCCA ID#	Phone	Fax			
SPECIMEN				Address				
Specimen Type <input type="checkbox"/> PB <input type="checkbox"/> BM Aspirate <input type="checkbox"/> MAA (<input type="checkbox"/> PB <input type="checkbox"/> BM) <input type="checkbox"/> FFPE Block <input type="checkbox"/> CGL Specimen <input type="checkbox"/> Other _____		Originating Hospital	Collection Date (dd/mmm/yyyy)	COPY PHYSICIANS (ALL INFORMATION IS NECESSARY)				
		Referring Lab/Hospital Sample ID	Tissue Type					
		Tumour Content	Tumour Cellularity					
REASON FOR TESTING / DIAGNOSIS / CLINICAL HISTORY (REQUIRED FOR TEST TO PROCEED)				Name		MSC		
				Address				
				Name		MSC		
				Address				
		CYTOGENETICS (FISH)		MOLECULAR				
LYMPHOID	Acute Lymphoblastic Leukemia		<input type="checkbox"/> BCR/ABL1 t(9;22) Diagnostic FISH <input type="checkbox"/> Karyotype		BCR/ABL1: <input type="checkbox"/> MRD Baseline <input type="checkbox"/> MRD Monitor <input type="checkbox"/> Kinase Domain			
	Chronic Lymphocytic Leukemia		<input type="checkbox"/> TP53, ATM, 13q14.3, CEN 12					
	Lymphoma		Anaplastic Large Cell		Clonality: <input type="checkbox"/> T-cell receptor <input type="checkbox"/> B-cell receptor			
			Burkitt					
			Double Hit					
			Follicular					
		MALT						
		Mantle Cell		<input type="checkbox"/> Pre-transplant assessment: <input type="checkbox"/> Donor <input type="checkbox"/> Recipient <input type="checkbox"/> Post-transplant assessment				
OTHER	Chimerism							
	Lymphoid and Myeloid neoplasm with Eosinophilia		<input type="checkbox"/> FIP1L1/PDGFR <input type="checkbox"/> PDGFRB <input type="checkbox"/> FGFR1					
	Multiple Myeloma		<input type="checkbox"/> FGFR3/IGH, TP53, MAF/IGH					
Other (with prior CGL Director's Approval)								
Physician Signature (required)						Date		
Lab Use Only		Tubes #	EDTA mL	NaHep mL	Media mL	FFPE Block	Tumour Content %	Cellularity %
		PB				Scrolls	Pathologist initials	
		BM				H&E	Notes	
		Other				IHC		
						Unstained		