CANCER GENETICS LABORATORY

BC Cancer Agency
CARE + RESEARCH

Provincial Health Services Authority
Province-wide solutions. Better health.

BRITISH COLUMBIA CANCER AGENCY
DEPT. OF PATHOLOGY AND LABORATORY MEDICINE
ROOM 3305 - 600 WEST 10TH AVENUE
VANCOUVER BC V5Z-4E6

604-877-6000 EXT 67-2094
WWW.CANCERGENETICSLAB.CA
INFO@CANCERGENETICSLAB.CA

ADDRESSOGRAPH OR PATIENT LABEL

MYELOID TESTING REQUISITION

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

PATIENT INFORMATION

Last Name	First and Middle Names		
Date of Birth dd/mmm/yyyy	**Sex** □ M □ F	**PHN**	**BCCA ID#**

REQUESTING PHYSICIAN

Name	MSC
Phone	**Fax**

Address

SPECIMEN

Specimen Type	Myeloid Panel Special Criteria	Collection Date (dd/mmm/yyyy)
□ PB □ BM Aspirate □ MAA (□ PB □ BM) □ CGL Specimen □ Other_____	**All**: Collect separate 0.5mL fresh marrow aspirate in EDTA **AML**: include cytogenetics report **MPN/MDS**: include marrow report (CGL fax: 604-877-6294)	**Referring Lab/Hospital Sample ID** **Originating Hospital**

COPY PHYSICIANS (ALL INFORMATION IS NECESSARY)

Name	MSC
Address	
Name	**MSC**
Address	
Name	**MSC**
Address	

REASON FOR TESTING / DIAGNOSIS / CLINICAL HISTORY (REQUIRED FOR TEST TO PROCEED)

		CYTOGENETICS (FISH)	MOLECULAR
MYELOID	**Acute Myeloid Leukemia**	□ Karyotype □ *RUNX1/RUNXITI* t(8;21) □ *CBFB* inv(16) □ *MLL/KMT2A* 11q23 rearrangement □ *ETV6/RUNX1* t(12;21)	**Myeloid panel** (restricted to LEUK/BMT physicians considering SCT) □ <70 y.o.; Good risk cytogenetics □ <70 y.o.; Intermediate risk cytogenetics **Single-gene testing** □ *FLT3*-ITD, NPM1 □ *KIT p.D816V* (CBF AML only)
	Acute Promyelocytic Leukemia	□ *PML/RARA* t(15;17) Diagnostic FISH □ Karyotype	*PML/RARA*: □ MRD Baseline □ MRD Monitor
	Chronic Myelogenous Leukemia	□ *BCR/ABL1* t(9;22) Diagnostic FISH □ Karyotype	*BCR/ABL1*: □ MRD Baseline □ MRD Monitor □ Kinase Domain
	Mastocytosis	□ *FIP1L1/PDGFRA* (with eosinophilia)	□ *KIT* p.D816V
	Myelodysplastic Syndrome	□ Karyotype	**Myeloid panel** (restricted to hematologists or hematopathologists) □ <60 y.o.; any karyotype □ 60-80 y.o.; normal marrow karyotype □ IPSS Int-1 or IPSS-R Intermediate; any karyotype
	Myeloproliferative Neoplasm	□ *BCR/ABL1* t(9;22) Diagnostic FISH	**Myeloid panel** □ *JAK2* V617F negative; ET/MF/PV; restricted to hematologists or hematopathologists □ *JAK2* V617F positive; MF; restricted to LEUK/BMT physicians considering SCT **JAK2 V617F Single-gene testing** □ Erythrocytosis (for men/women= Hb >165/160 g/L or HCT >49/48%) □ Thrombocytosis (>450x10^9/L) □ Leukoerythroblastic blood film □ Abdominal vein thrombosis □ PB/BM morphologic features of MPN (specify in clinical history box)
OTHER	**Chimerism**		□ Pre-transplant assessment: □ Donor □ Recipient □ Post-transplant assessment
	Lymphoid and Myeloid neoplasm with Eosinophilia	□ *FIP1L1/PDGFRA* □ *PDGFRB* □ *FGFR1*	
	Multiple Myeloma	□ *FGFR3/IGH, TP53, MAF/IGH*	
	Other (with prior CGL Director's Approval)		

Physician Signature (required) **Date**

Signature acknowledges an understanding that the Myeloid Panel may identify potential germline findings of hereditary significance

Lab Use Only

	Tubes #	EDTA mL	NaHep mL	Media mL	
PB					
BM					
Other					