CANCER GENETICS AND GENOMICS LABORATORY

LYMPHOID TESTING

BC CANCER
DEPT. OF PATHOLOGY AND LABORATORY MEDICINE
ROOM 3307 - 600 WEST 10TH AVENUE
VANCOUVER BC V5Z-4E6

604-877-6000 EXT 67-2094
FAX: 604-877-6294
MON-FRI 8:30AM-4:30PM
WWW.CANCERGENETICSLAB.CA
INFO@CANCERGENETICSLAB.CA

See website for Myeloid, Lymphoid, Solid Tumor and Hereditary Cancer information and requisitions

ADDRESSOGRAPH OR PATIENT LABEL

PATIENT INFORMATION

Last Name		First and Middle Names	
Date of Birth dd/mmm/yyyy	Gender ☐ M ☐ X ☐ F	PHN	BC Cancer ID#

REQUESTING PHYSICIAN (PLEASE SIGN BELOW)

Name	MSC
Phone	Fax
Address	

SPECIMEN

Specimen Type	Originating Hospital	Collection Date (dd/mmm/yyyy)
☐ PB ☐ BM Aspirate ☐ MAA (☐ PB ☐ BM) ☐ FFPE Block ☐ CGL Specimen ☐ Other________	Referring Lab/Hospital Sample ID	Tissue Type
	Tumour Content	Tumour Cellularity

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/KARYOTYPE)	MOLECULAR
LYMPHOID	**Acute Lymphoblastic Leukemia**	☐ *BCR/ABL1* t(9;22) Diagnostic FISH ☐ Karyotype	*BCR/ABL1*: ☐ MRD Baseline ☐ MRD Monitor ☐ Kinase Domain
	Chronic Lymphocytic Leukemia	☐ *TP53, ATM, 13q14.3, CEN 12*	
	Lymphoma Anaplastic Large Cell	☐ *ALK*	Clonality: ☐ T-cell receptor ☐ B-cell receptor
	Burkitt	☐ *MYC*	
	Double Hit	☐ *MYC* ☐ *BCL2* ☐ *BCL6*	
	Follicular	☐ *BCL2*	
	MALT	☐ *MALT*	
	Mantle Cell	☐ *CCND1/IGH*	
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*	

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		