

# CANCER GENETICS AND GENOMICS LABORATORY

## MYELOID 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

ADDRESSOGRAPH OR PATIENT LABEL

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

PATIENT INFORMATION						REQUESTING PHYSICIAN (PLEASE SIGN BELOW)							
Last Name			First and Middle Names			Name		MSC					
Date of Birth dd/mmm/yyyy		Gender <input type="checkbox"/> M <input type="checkbox"/> X <input type="checkbox"/> F	PHN		BC Cancer 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"/> CGL Specimen <input type="checkbox"/> Other _____		Myeloid Panel Special Criteria Collect separate 0.5mL fresh marrow aspirate in EDTA, plus:  AML: include cytogenetics, bone marrow, and flow cytometry report MPN/MDS: include marrow report		Collection Date (dd/mmm/yyyy)		COPY PHYSICIANS (ALL INFORMATION IS NECESSARY)							
				Referring Lab/Hospital Sample ID						Name		MSC	
				Originating Hospital						Address			
REASON FOR TESTING / DIAGNOSIS / CLINICAL HISTORY (REQUIRED FOR TEST TO PROCEED)						Name		MSC					
						Address							
						Name		MSC					
						Address							
			CYTOGENETICS (FISH/KARYOTYPE)			MOLECULAR							
						Myeloid panel may detect variants associated with hereditary conditions. See website or contact the lab for genes and details.							
MYELOID	Acute Myeloid Leukemia		<input type="checkbox"/> Karyotype (BM only) <input type="checkbox"/> FISH (specify probes): _____			<u>Myeloid panel</u> (restricted to LEUK/BMT physicians considering SCT) <input type="checkbox"/> <70 y.o.; Good risk cytogenetics <input type="checkbox"/> <70 y.o.; Int risk cytogenetics		<u>Single-gene testing</u> <input type="checkbox"/> KIT D816 V/F/H/Y (CBF AML only) <input type="checkbox"/> FLT3 (new Dx only) <input type="checkbox"/> NPM1 (Intermediate risk only)					
	Acute Promyelocytic Leukemia		<input type="checkbox"/> PML/RARA t(15;17) Diagnostic FISH <input type="checkbox"/> Karyotype (BM only)			PML/RARA: <input type="checkbox"/> MRD Baseline <input type="checkbox"/> MRD Monitor <input type="checkbox"/> query APL							
	Chronic Myelogenous Leukemia		<input type="checkbox"/> BCR/ABL1 t(9;22) Diagnostic FISH <input type="checkbox"/> Karyotype (BM only)			BCR/ABL1: <input type="checkbox"/> MRD Baseline <input type="checkbox"/> MRD Monitor <input type="checkbox"/> Kinase Domain Current therapy: _____							
	Mastocytosis		<input type="checkbox"/> FIP1L1/PDGFR (with eosinophilia)			<input type="checkbox"/> KIT D816 V/F/H/Y							
	Myelodysplastic Syndrome		<input type="checkbox"/> Karyotype (BM only)			<u>Myeloid panel</u> (restricted to hematologists or hematopathologists) <input type="checkbox"/> <60 y.o.; any karyotype <input type="checkbox"/> 60-80 y.o.; normal marrow karyotype <input type="checkbox"/> IPSS Int-1 or IPSS-R Intermediate; any karyotype							
	Myeloproliferative Neoplasm		<input type="checkbox"/> BCR/ABL1 t(9;22) Diagnostic FISH <input type="checkbox"/> Karyotype for MF or CMML (BM only)			<u>Myeloid panel</u> <input type="checkbox"/> JAK2 V617F negative; ET/MF/PV; restricted to hematologists or hematopathologists <input type="checkbox"/> JAK2 V617F positive; MF; restricted to LEUK/BMT physicians considering SCT		<u>JAK2 V617F Single-gene testing</u> <input type="checkbox"/> Erythrocytosis (Elevated RBC) <input type="checkbox"/> Elevated Hb/Hct (for men/women= Hb >165/160 g/L or HCT >49/48%) <input type="checkbox"/> Thrombocytosis (>450x10 <sup>9</sup> /L) <input type="checkbox"/> Leukoerythroblastic blood film <input type="checkbox"/> Abdominal vein thrombosis <input type="checkbox"/> Other (specify in clinical history)					
OTHER	Chimerism					Pre-transplant assessment: <input type="checkbox"/> Donor <input type="checkbox"/> Recipient <input type="checkbox"/> Post-transplant assessment							
	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 (BM only)										
PHYSICIAN SIGNATURE (REQUIRED)					DATE								
LAB USE ONLY		Tubes #	EDTA mL	NaHep mL	Media mL								
	PB												
	BM												
	Other												