



MOLECULAR HEMATOLOGY REQUISITION

PROVINCE	PERSONAL HEALTH NUMBER (PHN) _____	MEDICAL RECORD NUMBER
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Shaded areas are Required Information

ORDERING PHYSICIAN (Apply CLS Dr. Office Stamp Here): Last Name / Full First Name: Phone Number: 5 Digit Client #: Alpha Suffix Provider #:	PATIENT LAST NAME FULL FIRST NAME MIDDLE NAME			
	PATIENT ADDRESS CITY, PROVINCE POSTAL CODE			
COPY TO: 1) _____ _____ _____ Last Name Full First Name Office Address/Location 2) _____ _____ _____ Last Name Full First Name Office Address/Location	CHART NUMBER	GENDER	DATE OF BIRTH ____/____/____ Y Y Y Y / M M / D D	PATIENT PHONE NUMBER (____) _____ - _____
	ACCESSION NUMBER:			

TREATMENT SPECIFICS (DRUGS/DOSAGE/START DATE)	TRANSPLANTED: <input type="checkbox"/> YES <input type="checkbox"/> NO 1 ST Transplant Date: _____ 2 ND Transplant Date: _____
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DO NOT use this requisition for bone marrow test requests; see CLS form REQ9061BM *Bone Marrow Pathology Requisition*.

DO NOT use this requisition for **Chimerism Studies** **Screening/monitoring hematopoietic cell chimerism**

For peripheral blood chimerism testing, see CLS form FC3200 *Flow Cytometry Requisition*.
 For bone marrow chimerism test requests, see CLS form REQ9061BM *Bone Marrow Pathology Requisition*.

Philadelphia Chromosome Transcript Analysis (Nested PCR)	Screening for CML/ALL, BCR-ABL1 gene transcripts
<input type="checkbox"/> PHLR PB (Peripheral Blood)	

Quantitative PCR Analysis of BCR-ABL1 Fusion Gene Transcripts (Q-PCR)	Monitoring residual disease in CML
<input type="checkbox"/> QPCRPH1 (Peripheral Blood)	

APL Transcript Analysis (Nested PCR)	Screening/monitoring PML-RARA gene transcripts
<input type="checkbox"/> APL PB (Peripheral Blood)	

JAK2-V617F Mutation Analysis	Screening for myeloproliferative neoplasms
<input type="checkbox"/> JAK2 PB (Peripheral Blood)	

FLT3 and NPM1 Mutation Analysis*	Screening for FLT3 and NPM1 gene mutations
<input type="checkbox"/> FLT3 NPM1 PB (Peripheral Blood)	
*FLT3/NPM1 mutation analysis may include CEBPA testing if clinically indicated	

Molecular Hemostasis Studies (Factor VIII inversion, 2N vonWillebrand Factor, Multimers, Carrier Study: Hemophilia A, B or vWD)
<input type="checkbox"/> MH HEMST (Peripheral blood)
State test requested: _____
Family history: _____

Miscellaneous Test: Miscellaneous hemostasis (other than above) and oncology tests
<input type="checkbox"/> MH MISC (Peripheral blood)
State test requested: _____

COLLECTED BY:	COLLECTED AT:	PATIENT COLLECTED SPECIMENS	ACCESSION NUMBER
DATE COLLECTED	TIME COLLECTED	DATE OF COLLECTION: _____ YYYYY - MMM - DD	
		TIME OF COLLECTION: _____; _____ AM / PM (circle one)	