

# REQUEST FOR BONE MARROW ASPIRATION AND BIOPSY

Patient Name (last) \_\_\_\_\_  
 (first) \_\_\_\_\_  
 DOB (dd/mm/yyyy) \_\_\_\_\_  
 PHN \_\_\_\_\_ MRN \_\_\_\_\_  
 Account/Visit # \_\_\_\_\_  
**IH USE ONLY**

<b>Requesting Physician</b>	<b>REQUIRED – Clinical history / Imaging Data</b> <input type="checkbox"/> Lymphadenopathy <input type="checkbox"/> Hepatosplenomegaly <input type="checkbox"/> Skin lesions <input type="checkbox"/> Systemic symptoms <input type="checkbox"/> Known diagnosis: _____ <input type="checkbox"/> Staging
MSP #	
Contact number for report / fax	
Direct number	
<b>Copies to (name / phone / MSP #)</b> 1. _____ 2. _____ 3. _____	
<b>Medications</b> <input type="checkbox"/> Warfarin <input type="checkbox"/> DOAC <input type="checkbox"/> heparin <input type="checkbox"/> ASA <input type="checkbox"/> antiplatelet drugs <input type="checkbox"/> <a href="#">Group 1 hazardous medication</a> _____ <input type="checkbox"/> Steroids <input type="checkbox"/> Rituximab <input type="checkbox"/> G-CSF <input type="checkbox"/> Chemotherapy, specify: _____ <input type="checkbox"/> Other: _____ Last dose (specify medication): _____	

<b>Ancillary tests requested</b>	
<b>Classical cytogenetics</b> <input type="checkbox"/> Karyotype (BCCA) (e.g. suspected acute leukemia, MDS, MDS/MPN, MPNs)	<b>Molecular testing (BCCA)</b> <input type="checkbox"/> Myeloid mutation panel <input type="checkbox"/> CML PCR baseline study (PB) <input type="checkbox"/> JAK2 mutation (PB) <input type="checkbox"/> MRD RNA (PB and BM)
<b>Fluorescence in situ hybridization (FISH) studies (BCCA)</b> <input type="checkbox"/> Myeloma prognostic panel <input type="checkbox"/> BCR/ABL1 translocation <input type="checkbox"/> CLL/SLL prognostic panel <input type="checkbox"/> AML specific FISH (specify) _____ <input type="checkbox"/> Eosinophilia, or other (specify) _____	<b>Flow cytometry</b> <input type="checkbox"/> Lymphoid (BCCA) <input type="checkbox"/> Myeloid (blast phenotype, VGH) <input type="checkbox"/> Plasma cell myeloma (VGH, transplant candidate) <input type="checkbox"/> PNH testing (PB, VGH) <b>Other (specify)</b> _____

<b>Please check performing site and fax</b>	<b>IH Lab Use Only</b>	<b>Pathologist review</b>
<input type="checkbox"/> KGH (250) 862-4051	Location (outpatient/inpatient)	Approved <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> RIH (250) 314-2328	Collected by	Pathologist signature
<input type="checkbox"/> PRH (250) 492-9065	Collection date / time	Reviewed date
<input type="checkbox"/> KLH (250) 354-2310	Specimen case #	Priority: <input type="checkbox"/> Routine <input type="checkbox"/> Priority <input type="checkbox"/> Urgent
<input type="checkbox"/> KBRH (250) 364-3421		
<input type="checkbox"/> EKRH (250) 417-2973		
<input type="checkbox"/> VJH (250) 541-3501		