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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **REQUESTOR’S INFORMATION** | | | | | | | | | | | | | | **PATIENT’S INFORMATION** | | | | | | | | | | | | | |
| **Facility Name:** | |  | | | | | | | | | | | | **Name:** | |  | | | | | |  | | | | |  |
|  | |  | | | | | | | | | | | |  | | Last | | | | | | First | | | | Middle | |
| **Facility Address:** | |  | | | | | | | | | | | | **Address:** | | |  | | | | | | | | | | |
| Street, Room No. | | | | | | | | | | | | | | **Street** | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | |  | |  | | | | |  | |  | | | | |
| City/Town | | | | | | | | Province | | | Postal Code | | | **City/Town** | | | | | | | **Province** | | **Postal Code** | | | | |
| **Location:** | | | | |  | | | | | | | | | **Hospital ID No. (CR No.):** | | | | | | |  | | | | | | |
| **Phone Number:** | | | | |  | | | | | | | | | **Health Card Number (HCN):** | | | | | | |  | | | | | | |
| **Fax Number:** | | | | |  | | | | | | | | | **Health Card Version:** | | | | | | |  | | | | | | |
|  | | | | | | | | | | | | | | **Exp Date:** | | | | | | |  | | | | | | |
| **Ordering Physician:** | | | | |  | | | | | | | | | YYYYMMMDD | | | | | | | | | | | | | |
|  | | | | | Print | | | | | | | | | **DOB:** | |  | | | | | 🞏 **Male** | | | 🞏 **Female** | | | |
| **Physician Signature:** | | | | |  | | | | | | | | |  | | YYYYMMMDD | | | | |  | | |  | | | |
|  | | | | |  | | | | |  | | | |  | | | | | | | | | | | | | |
| **Specimen Collected by:** | | | | | | | |  | | | |  | | **Date:** | | | |  | | | | **Time:** | | |  | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **FLOW CYTOMETRY FOR MALIGNANT HAEMATOLOGY** | | | | | | | | | | | | |  | | **FLOW CYTOMETRY FOR IMMUNE STATUS** | | | | | | | | | | | | | |
| **CLINICAL INDICATION FOR INVESTIGATION:** | | | | | | | | | | | | | **QUANTITATIVE CELLULAR IMMUNODEFICIENCY SCREENING** | | | | | | | | | | | | | |
| 🞏 Acute Leukemia (AML/ALL) | | | | | | | 🞏 Lymphadenopathy | | | | | | **Specimen:** | | | | 1 lavender top EDTA tube | | | | | | | | | |
| 🞏 Myelodysplasia (MDS) | | | | | | | 🞏 Atypical Lymphocytes | | | | | | 🞏 **TBNK Lymphocyte Subset Enumeration (includes CD4)** | | | | | | | | | | | | | |
| 🞏 Cytopenias | | | | | | | 🞏 Lymphoma Staging | | | | | |  | | | | | | | | | | | | | |
| 🞏 Circulating Blast Cells | | | | | | | 🞏 Monoclonal Gammopathy | | | | | | **IMMUNOSUPPRESSIVE DRUG THERAPY MONITORING** | | | | | | | | | | | | | |
| 🞏 Lymphocytosis or LPD | | | | | | | 🞏 Plasma Cell Dyscrasia | | | | | | **Specimen:** | | | | 1 lavender top EDTA tube | | | | | | | | | |
| 🞏 Other: | | | |  | | | | | | | | | 🞏 **B cell Monitoring/Rituximab Therapy** | | | | | | | | | | | | | |
| **CURRENT THERAPY:** | | | | | | | | | | | | | 🞏 **T cell Monitoring/Anti-Thymocyte Globulin (ATG) Therapy**  🞏 **Other Biologic Therapy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | |
| 🞏 Rituximab/Obinutuzumab/Ofatumumab (anti-CD20) | | | | | | | | | | | | |  | | | | | | | | | | | | | |
| 🞏 Daratumumab (anti-CD38) | | | | | | | | | | | | | **FLOW CYTOMETRY SPECIALTY SEND OUT TESTING** | | | | | | | | | | | | | |
| 🞏 CD19-CART or Blinatumomab (anti-CD19)  🞏 Other immune therapy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | 🞏 **PNH** (Testing Facility – University Health Network) | | | | | | | | | | | | | |
| **SPECIMENS:** | | | | | | | | | | | | | 🞏 **Pediatric MRD** (Testing Facility – London Health Sciences Centre) | | | | | | | | | | | | | |
| 🞏 Peripheral Blood | | | | | | 1 lavender top EDTA tube | | | | | | | * Complete appropriate Testing Facility Laboratory Requisition * Specimen sent off site and requires overnight transport. Must be received in lab by 1300hrs to meet transport schedule. * **DO NOT** send on Fridays or day prior to STAT Holiday | | | | | | | | | | | | | |
| 🞏 Bone Marrow Aspirate | | | | | | 1 green top sodium heparin tube | | | | | | |
| 🞏 CSF | | | | | | Sterile Container (no additive) | | | | | | |
| 🞏 Body Fluid | | | | | | Sterile Container (no additive) | | | | | | |  | | | | | | | | | | | | | |
| Anatomic Site: | | | | | |  | | | | | | | **LABORATORY INFORMATION** | | | | | | | | | | | | | |
| 🞏 Solid Tissue | | | | | | Sterile Container (in sterile saline) | | | | | | | Hours of Operation | | | | | **Monday to Friday 0800-1600** | | | | | | | | |
| Anatomic Site: | | | | | |  | | | | | | | Hours of Specimen Receipt | | | | | **Monday to Thursday 0800-1600** | | | | | | | | |
| 🞏 Fine Needle Aspirate | | | | | | Sterile Container (no additive) | | | | | | |  | | | | | **Friday 0800-1300** | | | | | | | | |
| Anatomic Site: | | | | | |  | | | | | | | Statutory Holidays | | | | | **Closed** | | | | | | | | |
| 🞏 Bronchial Alveolar Lavage | | | | | | Sterile Container (no additive) | | | | | | | * Please consider the pre-analytical TAT (including transportation), laboratory hours of operation and laboratory hours of specimen reception when sending a sample for flow cytometry testing. * Specimens received after 1300hrs on Friday may be rejected for testing unless pre-arranged with laboratory medical director. | | | | | | | | | | | | | |
| Anatomic Site: | | | | | |  | | | | | | |
|  | | | | | | | | | | | | |
| **INVESTIGATION REQUIRED:** | | | | | | | | | | | | |
| 🞏 **Diagnostic** | | | 🞏 **Staging** | | | | | | 🞏 **Follow-up** | | | |