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|  | **KHSC CLINICAL LABORATORY SERVICES**  **CORE LABORATORY**  **PHONE: (613)-549-6666 ext. 7806**  **REQUISITION FOR**  **BRONCHOALVEOLAR LAVAGE (BAL)**  **SPECIMENS ONLY** |

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| **SAMPLE COLLECTED:**  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time \_\_\_\_\_\_ Location\_\_\_\_\_\_\_  *yyyy / mm / dd hhmm*  **Physician Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *Collection site:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | CR# or Hosp. ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(M/F)\_\_\_\_    Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Health#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_/\_\_\_/\_\_\_  *yyyyy /mm / dd*  Physician **\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **PRINCIPAL DIAGNOSIS:** |

**Ordering Instructions:**

* Order BALDIF Only (Fluid type FBAL)

**Collection Instructions*:***

* Place a minimum of 20 mL of aspirated fluid into a sterile collection container.
* Maintain specimen at room temperature until delivery.
* Deliver specimen to Core Lab specimen receiving ASAP after collection***.***

***Note: Samples MUST be received in the laboratory before 1300 hours to obtain optimum cell preservation and allow sufficient time for processing.***

**Tests Required:**

**☑** **Hematology:** Relative(%) Differential Count Only

□ **Flow cytometry**: (Please check indication)

**□** **Sarcoidosis assessment (**CD4/CD8 subset only performed when lymphocytes >15%)

**□** **Lymphoma assessment**

**□** **Other: Please indicate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Specimen Label*

*(Lab Use Only)*