Molecular Hematology Oncology Test Requisition

Molecular Genetics Laboratory
Kingston Health Sciences Centre
76 Stuart Street, Douglas 4 Rm8-415
Kingston ON K7L 2V7
613-549-6666 x 4892 **FAX**: 613-548-1356
In house delivery tube station: # 31

Place Patient Addressograph HERE

Patient Name: ______________________________

Date of Birth (YYYY/MM/DD): ___________________

Health Card Number: ____________________________

Patient Sex: M / F / U *Version Code*

*Patient Address:*________________________________

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Please complete and submit accompanied by a labelled specimen, with the same two unique identifiers for testing.

Specimen Requirements	
Collection Centre:	Specimen Type:
Collection Date: (YYYY/MM/DD)	☐ Blood 3-6mL – EDTA Vacutainer
Collection Time:	☐ Bone Marrow Aspirate - EDTA Vacutainer
Collected By:	☐ Other (please specify):

For RNA tests specimen must be received within the lab within 24 hours of collection.

Issue Report To: Authorizing Health Care Provider		
Name:		Phone Number:
Institution Address:		Fax Number:
		Authorizing Signature:
CPSO#:	OHIP Billing:	

CLINICAL HISTORY

DISEASE CODE	TEST REQUESTED	
☐ PMLRAR	**Diagnostic** PML::RARA Fusion t(15;17)	**RNA**
☐ FLT3NPM1	**Diagnostic**/Relapsed FLT3 & NPM1 (FLT3-ITD, FLT3-TKD, NPM1 Ex12 insertion)	DNA
☐ RT-BCR/ABL	**Diagnostic BCR::ABL** Qualitative Assessment (Major and Minor breakpoints)	**RNA**
☐ QRT BCR/ABL	**Follow-up Quantitative BCR::ABL** Breakpoint Monitoring (**p210/Major only**)	**RNA**
☐ SEND OUT	**Follow-up Quantitative BCR::ABL** Breakpoint Monitoring (**Minor**/other breakpoints) *Please include completed UHN requisition*.	**RNA**
☐ MPN	Myeloproliferative Neoplasm Panel JAK2 V617F, JAK2 Ex12, CALR Ex9, MPL W515K/L	DNA
☐ SMLP	Somatic Myeloid Lymphoid Panel; NGS, multiple gene targets (KIT included).	DNA

Please leave blank *For* **genetics** *LAB Use Only*