SASKATOON
HEALTH REGION

DEPARTMENT OF
LABORATORY MEDICINE

CANCER CENTRE REQUISITION STEM CELL PROGRAM

Clinical Diagnosis: ……
Requesting Physician: ……..
Additional Copies of Report to: 1. …… 2. ……..
Collection (Date & Time) ……
Priority:

☐ **ROUTINE** ☐ **URGENT**

☐ **STAT** ☐ **TIMED (specify): ……..(hours)**

Stem Cell Package One

☐ **SCP1**
CBC, LYTE4, CREAT, UREA, ALP, ALB, ALT, AST, BILIT, MG

Stem Cell Package Two

☐ **SCP2**
CBC, LYTE4, CREAT, UREA, ALP, ALB, ALT, AST, BILIT, MG, CA, GGT, GLUCR, PHOS

☐ **CC LD**

☐ **Tacrolimus/FK506**

☐ **PT (INR)**

☐ **Cyclosporin A**

Other Tests (specify):

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