Saskatchewan Health Authority

Patient Label

NAME: _____

HSN: _____

D.O.B.: _____

DEPARTMENT OF LABORATORY MEDICINE

FLOW CYTOMETRY REQUISITION

❑ RUH ❑ SCH ❑ SPH ❑ Other _____

Requesting physician: _____

Copies of report to 1. _____

2. _____

Collection date and time: _____

CLINICAL INFORMATION (past and present)**:**

SPECIMEN TYPE AND SITE (source)**:**

❑ Peripheral Blood ❑ CSF

❑ Bone marrow (specify site): _____

❑ Lymph node (specify site): _____

❑ Biopsy (specify site): _____

❑ Fluid (specify site): _____

❑ Other (specify type and site): _____

TEST REQUESTED:

❑ **CD4C8** (CD3/CD4/CD8, T Cell Subsets in Peripheral Blood [Percent and Absolute Values])

❑ **CD34P** Absolute CD34 (HPC); pre-harvest only

❑ **FLOWC** All other testing by Flow Cytometry (specify)

- ❑ Pediatric lymphocyte subsets
- ❑ Lymphoma, Chronic Lymphocytic Leukemia
- ❑ Acute Leukemia
- ❑ Myeloma or other plasma cell dyscrasia
- ❑ CD19, CD20
- ❑ Other (specify) _____

NOTE: Adequate clinical information is essential for accurate diagnosis.

NOT FILED ON PERMANENT HEALTH RECORD