CYTOGENETICS LABORATO
DEPARTMENT OF PATHOLOGY
ROYAL UNIVERSITY HOSPITAL
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Benefits of providing COMPLETE and LEGIBLE information:
- Reduces turnaround time when processing patient samples
- Promotes patient safety through reduced transcription errors

Addressograph or Label

Patient identification **MUST** include:
- First and last name
- PHN or other unique identifier
- Date of birth

This information may be on a label or in writing.

ALL sections must be completed to avoid delays in processing.

PATIENT INFORMATION

Patient Name: _____ Gender: ☐ M ☐ F
(SURNAME) (GIVEN NAME)

Address: _____ Phone (Home/Work): _____

PHN/HSN: _____ RUH#: _____ Date of Birth (dd/mm/yy): _____

☐ Outpatient ☐ Inpatient: Ward _____ Kindred #: _____

PHYSICIAN INFORMATION

Please provide physician's **full** name

Ordering Physician: _____ Phone: _____

Copy to: _____ Phone: _____ Fax

Copy to: _____ Phone: _____ Fax

Failure to provide required information may result in delays in service

TEST REQUESTED

☐ Chromosome Analysis

☐ FISH (please specify probe): _____

☐ Tissue Culture: ☐ Frozen storage ☐ Shipment

SPECIMEN INFORMATION

Collection Date (dd/mm/yy): _____

Choose specimen type and check off indication (or write in Other Indication /Information space below)

SPECIMEN TYPE AND CLINICAL INDICATION

Amniotic Fluid
15-20mL in sterile tubes, e.g. Corning or Falcon

Gestational Age:

_____
Twin Pregnancy: ☐ Twin A ☐ Twin B

CLINCAL INDICATION
☐ Positive MSS (include report)
☐ Anomalies (please specify in "Other" field below)
☐ Fetal growth restriction
☐ Maternal age >40
☐ Previous pregnancy with chromosomal abnormality (please specify in "Other" field")
☐ Family history of chromosome abnormality (please specify in "Other" field)
☐ [illegible]etic
[illegible]ed

Blood
- 2-7 mL in a green top, **SODIUM HEPARIN** tube;
- 1-3 mL for neonates

CLINCAL INDICATION
☐ Aneuploidy (please specify in "Other" field below)
☐ Congenital anomalies
☐ Ambiguous genitalia
☐ Dysmorphic features
☐ Failure to thrive
☐ Developmental Delay
☐ Sex chromosome abnormality
☐ Short stature
☐ Excessive growth
☐ Infertility
☐ Multiple miscarriages (≥3)
☐ Family history of chromosome abnormality

☐ Bone Marrow /☐ Oncology Blood
1-3 mL BM or 2-7 mL blood in a green top, **SODIUM HEPARIN** tube or sterile tube with transport media

☐ New Diagnosis
☐ Follow-up ☐ Relapse
☐ Post Treatment
☐ Post Transplant

CLINCAL INDICATION
☐ AML ☐ CLL
☐ APL ☐ MM/PCD
☐ ALL ☐ Lymphoma
☐ MDS ☐ MPD
☐ CML ☐ Potential donor

Solid Tissue
0.5 x 0.5 cm in a sterile container with **STERILE SALINE/MEDIA**

Source (e.g. skin, POC):

_____

CLINCAL INDICATION
☐ Multiple miscarriages (≥3)
☐ Fetal anomaly/malformation
☐ Culture for biochemical or DNA Testing

☐ Other Indication/Information: _____

Clinical Indication: Karyotype is NOT acceptable

Ordering physician signature required

Ordering Physician Signature:_____ **(REQUIRED)**

SE ONLY:

Received Date: _____ Lab Number: _____ Initials: _____
(dd/MON/yyyy) or stamp

Specimen Details: _____
(e.g. container(s); volume; quality)