Saskatoon Health Region

Benefits of providing COMPLETE and LEGIBLE information:
- Reduces turnaround time when processing patient samples
- Promotes patient safety through reduced transcription errors

H t Requisition

Please Complete ALL Sections

COLLECTION INFORMATION

Collection Facility: _____
(Hospital, Ward)

Collection Date: _____

Collected By: _____

DELIVER TO

DNA BANKING or SEND OUT:
Cytogenetics Laboratory
Royal University Hospital Ellis Hall Room 35
103 Hospital Dr, Saskatoon, S7N 0W8
Phone: 306-655-1706 FAX: 306-655-6462

OTHER TESTS:
Human Molecular Genetics Laboratory
Royal University Hospital Rm 2848
103 Hospital Dr, Saskatoon, S7N 0W8
Phone: 306-655-2184 FAX: 306-655-2223

PATIENT INFORMATION (Print, Addressograph or Label)

Patient Name: _____

PHN/HSN: _____

Date of Birth (d

Address: _____

_____

Telephone: _____

SEX: ☐M ☐F RUH #: _____

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.

PHYSICIAN INFORMATION

Referring Physician: _____

Please provide physician's **full** name

Address: _____

Copy to: _____

Address: _____

Phone: _____

Fax: _____

Phone: _____

Fax: _____

Indicate reason for test

TEST REQUESTED	SAMPLE REQUIRED (Indicate sample type submitted by test)
☐ DNA Banking ☐ Send out	☐ Blood 2 X 4 ml EDTA ☐ Blood 3 ml EDTA (infant only) ☐ Cultured Cells
☐ Factor V Leiden ☐ Prothrombin (PR202)	☐ Blood 4 ml EDTA
☐ CCND1/IGH [t(11;14)]* ☐ BCL2/IGH [t(14;18)]* ☐ B-cell Clonality* ☐ T-Cell Clonality*	☐ Blood 4 ml EDTA ☐ Bone Marrow 1-4 ml EDTA ☐ FFPE tissue block ☐ Body Fluid ☐ Fresh/Frozen Tissue
☐ BCR/ABL1 (p210) ☐ JAK2 (V617F) ☐ FLT3 / NPM1	☐ Blood 4-8 ml EDTA (8 ml for BCR/ABL1) ☐ Bone Marrow 1-4 ml EDTA

REASON FOR TEST

☐ Confirm Clinical Diagnosis ☐ Predictive testing

☐ Carrier Status ☐ Prenatal Diagnosis

PRIORITY

☐ Routine ☐ STAT Reason: _____

Indicate priority

CLINICAL INFORMATION AND FAMILY HISTORY

Failure to provide required information may result in delays in service

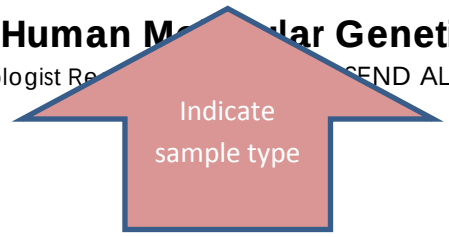
Indicate test requested

FO E ONLY

Dat _____ Lab Number: _____ Tubes Received: _____ Initials: ____

Human Molecular Genetics Test Requisition

* Clearance by Hematopathologist Re... SEND ALL BUT FROZEN SPECIMENS AT **ROOM TEMPERATURE**



FOR LABORATORY USE ONLY

Date Received: _____ Lab Number: _____ Tubes Received: _____ Initials: ____