Saskatchewan Health Authority

Patient Label

NAME: _____

HSN: _____

D.O.B.: _____

❑ RUH ❑ SCH ❑ SPH ❑ Other _____

DEPARTMENT OF PATHOLOGY & LABORATORY MEDICINE

HUMAN MOLECULAR GENETICS TEST REQUISITION

Please complete ALL sections.

PATIENT INFORMATION

Patient name: _____ Gender: ❑ Male ❑ Female
(Surname) (Given name)

Address: _____

Phone (Home/Work): _____

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

PHYSICIAN INFORMATION

Referring physician: _____ Phone: _____

Address: _____ Fax: _____

Copy to: _____ Phone: _____

Address: _____ Fax: _____

COLLECTION INFORMATION

Collection facility (Hospital/Ward): _____

Collection date: _____ Collected by: _____

DELIVER TO

Human Molecular Genetics Laboratory
Royal University Hospital, Room 2848
103 Hospital Drive, Saskatoon, SK S7N 0W8
Phone: 306-655-2184 | Fax: 306-655-2223

TEST REQUESTED	**SAMPLE REQUIRED** (indicate sample type submitted by test)	**REASON FOR TEST** ❑ Confirm clinical diagnosis ❑ Predictive testing ❑ Carrier status ❑ Prenatal diagnosis
❑ Factor V Leiden ❑ Prothrombin (PR202)	❑ Blood 4 mL EDTA	**CLINICAL INFORMATION AND FAMILY HISTORY**
❑ 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)	❑ Blood 4 mL EDTA ❑ Bone marrow 1-4 mL EDTA	

*Clearance by hematopathologist required

Please send all but frozen specimens at room temperature.

FOR LABORATORY USE ONLY

Date received: _____ Lab number: _____ Tubes received: _____ Initials: _____