Regional Molecular Diagnostics and Cytogenetics Requisition

ALL INFORMATION MUST BE LEGIBLE

Please call local phlebotomy clinic to book blood work appointments for this requisition, do not use self-booking for genetic testing.

Appointment priority ❑ **Routine** ❑ **Urgent** ❑ **STAT** ❑ **Non-insured: Horizon Staff** ❑ **Non-insured: Private Practice**

Mandatory Information

Patient's Last Name:

First Name:

NB Medicare #: (If no NB Medicare # is present, Other Patient # and Address is required)

Expiry Date:

DOB: **D** **M** **Y** **Sex:**

Ordering Provider: (First & last name, specialty,)

Copies to: (First & last name, specialty)

Fax to: (Fax number)

Other Information

Patient Location:

Account #:

Other Provincial Healthcare # & Province or Patient #:

Address:

Province: **Postal Code:**

Reoccurring Frequency:

Relevant Clinical/ Medication Information:

NOTE: Specimens MUST be labelled with patient's full name, Medicare number, date and time, Phlebotomist Identification

Collection Date:		**Time:**		**Collection Location:**	
Collected by:				**Full Signature:**	

All fields must be filled. Requisitions with incomplete clinical information will be returned for completion.

Solid Tumor Testing (Performed on tissue)

Institutions outside Saint John Regional Hospital are required to attach a CBC, Bone Marrow, and/or Pathology Report with their sample as applicable.

Specimen/Tissue Type: _____

Tumor Type: _____

Case/Block Number: _____

% Tumor Cells: _____

Minimum 20% tumor cells required for testing.

Paraffin Embedded Tissue (Surgical and Cell Blocks)

Must be accompanied by an H&E slide marked with tumor % determined by a pathologist designated on the slide and requisition.

- ❑ 3 Curls (10 microns thick each)
- ❑ 3 Scored Curls (10 microns thick each)
- ❑ Block
- ❑ 12 Unstained Slides

Solid Tumor:

(✓)	Test Name	(✓)	Test Name
	NGS – Pan Cancer Panel (550+ genes)		Miscellaneous send out test(s), specify:

The NGS Pan Cancer Panel is a comprehensive genomic profiling (CGP) assay that may be used to test the following tumor types: **Endometrium, Ovary, Breast, Pancreas, Lung, Colon, Gastrointestinal Stromal Tumor, Esophageal/Gastroesophageal, Brain, Melanoma, Salivary Glands, Thyroid, Pancreas, Bladder, Prostate, Lymphoma, Kidney, Mesothelioma, Endocrine Glands, and any Advanced Stage Malignancy. This assay is designed to capture fusions seen in Carcinoma but NOT in Sarcoma.**

A complete list of genes can be found in the Saint John Area Lab Manual https://www.horizonnb.ca/lab-resources

For hereditary cancer syndrome testing in patients with NO PERSONAL HISTORY of cancer, physicians can contact genetics@HorizonNB.ca

Mandatory Information						
	Patient's Last Name:					**If faxing, complete all Mandatory information**
	First Name:					
	NB Medicare #: If no NB Medicare # is present, Other Patient # and Address is required			**Expiry Date:**		**Relevant Clinical/ Medication Information:**
	DOB:	**D**	**M**	**Y**	**Sex:**	
	Ordering Provider:	(First & last name, specialty,)			**Copie to:**	(First & last name, specialty,)

Haematologic Testing

Institutions outside Saint John Regional Hospital are required to attach a CBC, Bone Marrow, and/or Pathology Report with their sample as applicable.

Ref. Lab Specimen ID: _____

Tissue Type: ❑ Peripheral Blood ❑ Bone Marrow

Purpose of Test: ❑ Diagnostic ❑ Monitoring

Clinical History: _____

_____

Prior Bone Marrow Transplant:

- ❑ Yes
- ❑ No
- ❑ Unknown

If yes, what was the gender of the donor?

- ❑ Self
- ❑ Non-self
  - ❑ Male
  - ❑ Female
  - ❑ Unknown

Was a Peripheral Blood or Bone Marrow sample from this patient tested by NGS or OGM before?

- ❑ Yes
- ❑ No
- ❑ Unknown

If yes, enter date last tested: _____

Current therapy: _____

Diagnosis or Working Diagnosis: (Choose at least one)

- ❑ Acute Myeloid Leukemia
- ❑ Acute Lymphoid Leukemia
- ❑ Chronic Myeloid Leukemia
- ❑ Chronic Lymphoid Leukemia/Small Cell Lymphoma
- ❑ B-Cell Neoplasm/ Lymphoma
- ❑ T-Cell Neoplasm/ lymphoma
- ❑ Myelodysplastic Syndrome (MDS)
- ❑ Myeloproliferative Neoplasm (MPN)
- ❑ Multiple Myeloma (MM)
- ❑ Anemia
- ❑ Leukocytopenia
- ❑ Thrombocytopenia
- ❑ Multi or pancytopenia
- ❑ Polycythemia
- ❑ Thrombocytosis
- ❑ Leukocytosis
- ❑ Multi or Pancytosis
- ❑ Other: _____

(✓)	Test Name	(✓)	Test Name
	Bank Total NA/DNA/RNA		BCR-ABL p210 and p190 – Diagnostic
	Bank Haematology OGM		FLT3-ITD & D835
	BCR-ABL p210 – Monitoring		NGS – Myeloid Malignancies Panel
	BCR-ABL p190 – Monitoring		JAK2 (V617F)
	Miscellaneous send out test(s), specify:		
	Haematological Cytogenetics by OGM* ❑ CD138 Cell Sorting (Plasma cell Dyscrasia/MM only)		

**Optical Genome Mapping (OGM) is a WHOLE GENOME CYTOGENOMICS technology replacing Karyotyping and FISH and eliminating the need for panels.*

Order this assay in clinical scenarios where you would order karyotyping, FISH or both.

The limit of detection (LOD) of this assay is a VAF of 5-7%. Submitted samples must contain at least 10% of the atypical cell population in question (ex: blasts, etc.)

This assay is not currently validated for Minimal Residual Disease.

A minimum of 4 mL sample is required.

Please make sure to indicate "Cell sorting" for Plasma Cell Dyscrasia/ Multiple Myeloma samples.