

CYTOGENETICS LABORATORY

555 University Avenue
Room 3415, Black Wing
Toronto, ON, M5G 1X8, Canada

Tel: 416-813-7200 x 1
Fax: 416-813-7732
(CLIA # 99D1014032)

Patient Name: _____

Date of Birth (DD/MM/YYYY): _____

Gender: Male Female

Parent's Name: _____

Address: _____

MRN#: _____

For Canada Only

Health Card #: _____

Issuing Province _____

Version: _____

CYTOGENETICS ONCOLOGY

Referred-In Requisition

SPECIMEN COLLECTION	SPECIMEN TYPE AND INFORMATION
DATE (DD/MM/YYYY) _____ TIME (HH:MM) _____ SHIPPING INSTRUCTIONS <ul style="list-style-type: none"> Send all specimens to Cytogenetics Laboratory, at the shipping address indicated above After hours, deliver to Rapid Response Laboratory, Room 3642 Courier tracking information may be emailed to: cytogenetics.requests@sickkids.ca 	<input type="checkbox"/> Bone marrow aspirate – 3 mLs in sodium heparin tube; transport at room temperature <input type="checkbox"/> Peripheral blood – 3-6 mLs in sodium heparin tube; transport at room temperature <input type="checkbox"/> Solid tumour – 2-3 mm ³ fresh tissue in transport medium or sterile PBS. Do not freeze. Transport ASAP <input type="checkbox"/> Tumour tissue in paraffin – minimum two slides with 4 micron FFPE sections. Corresponding marked H&E slide requested if selected area to be analyzed SickKids Pathology Case #: _____ External <input type="checkbox"/> Pathology report attached <input type="checkbox"/> Pathology report pending

INDICATION FOR TESTING	
Haematopoietic <input type="checkbox"/> New leukemia <input type="checkbox"/> Relapse <input type="checkbox"/> MDS <input type="checkbox"/> End of Induction <input type="checkbox"/> Pancytopenia <input type="checkbox"/> Bone marrow involvement <input type="checkbox"/> Follow up <input type="checkbox"/> Anemia <input type="checkbox"/> Other: _____	Solid tumour/lymphoma Tumour type: _____ Site of biopsy: _____

TEST(S) REQUESTED	<input type="checkbox"/> Process and hold pending Pathology report/results	<input type="checkbox"/> KARYOTYPE
FISH Leukemia/Lymphoma ALL <input type="checkbox"/> B-ALL FISH panel <input type="checkbox"/> Hyperdiploidy FISH probes <input type="checkbox"/> ETV6-RUNX1 (TEL-AML1) <input type="checkbox"/> BCR-ABL1 <input type="checkbox"/> MLL <input type="checkbox"/> TCF3 (E2A) <input type="checkbox"/> CDKN2A (P16) <input type="checkbox"/> IGH <input type="checkbox"/> CRLF2 <input type="checkbox"/> ZNF384 <input type="checkbox"/> TCRα/δ Myeloproliferative <input type="checkbox"/> BCR-ABL1 <input type="checkbox"/> PDGFRα <input type="checkbox"/> PDGFRβ	FISH Solid tumours Aneurysmal bone cyst Nodular fasciitis <input type="checkbox"/> USP6 Alveolar rhabdomyosarcoma <input type="checkbox"/> FOXO1 (FKHR) Dermatofibrosarcoma protuberans <input type="checkbox"/> PDGFB Ewing's tumours <input type="checkbox"/> EWSR1 Infantile fibrosarcoma <input type="checkbox"/> ETV6 Liposarcoma <input type="checkbox"/> DDIT3 (CHOP) <input type="checkbox"/> FUS RCC/ASPS/PEComa <input type="checkbox"/> TFE3 Retinoblastoma <input type="checkbox"/> RB1	Rhabdoid <input type="checkbox"/> INI1 (SMARCB1) Synovial sarcoma <input type="checkbox"/> SS18 (SYT) Undifferentiated sarcoma <input type="checkbox"/> CIC Nervous system Astrocytoma <input type="checkbox"/> BRAF Ependymoma <input type="checkbox"/> RELA Medulloblastoma <input type="checkbox"/> MYC <input type="checkbox"/> MYCN <input type="checkbox"/> MYB/CEP6 Neuroblastoma <input type="checkbox"/> MYCN <input type="checkbox"/> 1p36 Oligodendroglioma <input type="checkbox"/> 1p36/1q25 & 19q13/19p13

Referring Physician Name (print) _____ Address _____ Phone _____ Fax _____ Signature (required) _____	Copy of Report Name (print) _____ Address _____ _____ _____
--	--

FOR LABORATORY USE			
Date Received #: _____	Technologist: _____	Cultures set: _____	IndicationCode(s): _____
Lab #: _____	Genetics #: _____	Harvest Date (D): _____	Specimen/Requisition Code(s): _____
Lab #: _____	Volume: _____ Cell count: _____	Harvest Date (C): _____	_____

Patient Name: _____

Date of Birth (DD/MM/YYYY): _____

Gender: Male Female

MRN#: _____

BILLING FORM

CYTOGENETICS ONCOLOGY

At your direction, we will bill the hospital, referring laboratory, referring physician, or a patient/guardian, for the services we render

- Invoices are sent upon completion of each test/service.
- Invoices are itemized and include the date of service, patient name, test name and charge.
- Contact SickKids' Cytogenetics Laboratory at 416-813-7200 x1 with billing inquiries.

How to complete the Billing Form:

- Referring Physician completes the appropriate section below to specify billing method.
- Send requisition and completed "Billing Form" with specimen.

Section 1: Complete to have the Healthcare Provider billed:

Your Referring Laboratory's Reference #: _____

Billing address of hospital, referring laboratory, clinic, referring physician, or medical group: (if different from requisition):

Name: _____

Address: _____

City: _____ Prov/State: _____

Postal/Zip Code: _____ Country: _____

Section 2: Complete to have Patient/Guardian billed directly:

If you elect to have patient/guardian billed:

- Patient/Guardian billing information below must be complete; otherwise, the healthcare provider will be billed.
- Please advise the patient/guardian to expect a bill from our laboratory.
- Provide us with patient's valid credit card information.
- Unfortunately, we cannot accept personal checks.
- **In this case, the patient/guardian is solely responsible for the charges.**

Send bill to (check one): Patient Guardian

Method of Payment (check one): American Express MasterCard Visa

Name as it appears on credit card: _____

Credit card #: _____

Expiry date on credit card: _____

Signature of credit card holder (Required): _____

Mailing Address of Patient/Guardian (if different from requisition):

Name: _____

Address: _____

_____ Apt. #: _____

City: _____ Prov/State: _____

Postal/Zip Code: _____ Country: _____

Additional Contact Information

Patient's phone # with area code: _____

- or -

Guardian's phone # with area code: _____