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SickKids
THE HOSPITAL FOR SICK CHILDREN
Paediatric Laboratory Medicine

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 #: *Version:*
Issuing Province

CYTOGENETICS ONCOLOGY

Referred-In Requisition

SPECIMEN COLLECTION

DATE (DD/MM/YYYY)

TIME (HH:MM)

SHIPPING INSTRUCTIONS

- 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

SPECIMEN TYPE AND INFORMATION

☐ **Bone marrow aspirate** – 3 mLs in sodium heparin tube; transport at room temperature

☐ **Peripheral blood** – 3-6 mLs in sodium heparin tube; transport at room temperature

☐ **Solid tumour** – 2-3 mm^3 fresh tissue in transport medium or sterile PBS. Do not freeze. Transport ASAP

☐ **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 ☐ **Pathology report attached**
☐ **Pathology report pending**

INDICATION FOR TESTING

Haematopoietic

☐ New leukemia ☐ Relapse ☐ MDS
☐ End of Induction ☐ Pancytopenia ☐ Bone marrow involvement
☐ Follow up ☐ Anemia ☐ Other: _____

Solid tumour/lymphoma

Tumour type: _____

Site of biopsy: _____

TEST(S) REQUESTED

☐ **Process and hold pending Pathology report/results** ☐ **KARYOTYPE**

FISH Leukemia/Lymphoma

ALL
☐ B-ALL FISH panel
☐ Hyperdiploidy FISH probes
☐ ETV6-RUNX1 (TEL-AML1)
☐ BCR-ABL1
☐ MLL
☐ TCF3 (E2A)
☐ CDKN2A (P16)
☐ IGH
☐ CRLF2
☐ ZNF384
☐ TCRα/δ

Myeloproliferative
☐ BCR-ABL1
☐ PDGFRα
☐ PDGFRß

AML
☐ CBFB (inv(16), t(16;16))
☐ MLL
☐ PML-RARα
☐ RUNX1/RUNX1T1 (AML1/ETO)
☐ Chromosomes 5 and 7

Lymphoma
☐ ALK
☐ MYC (8q24)
☐ IGH/BCL2
☐ BCL6
☐ IGH/CCND1
☐ MALT1

☐ Other: _____

FISH Solid tumours

Aneurysmal bone cyst Nodular fasciitis
☐ USP6

Alveolar rhabdomyosarcoma
☐ FOXO1 (FKHR)

Dermatofibrosarcoma protuberans
☐ PDGFB

Ewing's tumours
☐ EWSR1

Infantile fibrosarcoma
☐ ETV6

Liposarcoma
☐ DDIT3 (CHOP)
☐ FUS

RCC/ASPS/PEComa
☐ TFE3

Retinoblastoma
☐ RB1

Rhabdoid
☐ INI1 (SMARCB1)

Synovial sarcoma
☐ SS18 (SYT)

Undifferentiated sarcoma
☐ CIC

Nervous system

Astrocytoma
☐ BRAF

Ependymoma
☐ RELA

Medulloblastoma
☐ MYC ☐ MYCN ☐ MYB/CEP6

Neuroblastoma
☐ MYCN ☐ 1p36

Oligodendroglioma
☐ 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):** _____

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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:

_____