Molecular Genetics Laboratory
Oncology Studies Requisition
76 Stuart Street, Douglas 4, Room 8-415
Kingston, ON K7L 2V7
Tel: (613) 549-6666 ext. 4892
FAX: 613-548-1356
In-house delivery tube station: #31
http://www.kgh.on.ca/healthcare-providers/lab-requisition-forms

CR# or Hospital ID #: ______________________

Patient Name: __________________________________________________________
(Last)                                                      (First)

Date of Birth (YYYY/MM/DD):   _____/_____/_____     Sex:  M/F

Health Card #: ____________________________  Expiry Date: _________

Address: ________________________________________________________________

Postal Code: ________________      Phone:  ________________________

Specimen Requirements
Collection Centre: ___________________________________      Collected by: ___________________________(please print)

Date (YYYY/MM/DD):  ________/____/____    Time:  ___________

☐ Collected at Room Temperature and within 24 hours

Note:  The requisition and specimen must carry the same two unique patient identifiers or the sample may be rejected.

☐ Blood (10 cc - EDTA vacutainer - lavender or pink)      ☐ Lymph Node
☐ Bone Marrow (EDTA rinsed syringe)      ☐ Other Tissue (specify): __________________________

Principal Diagnosis and Therapy

Test Requested
☐ Hematopathologist to Triage (DNA will be held until hematopath review completed)
☐ Immunoglobulin/T cell receptor gene rearrangements
☐ JAK2
☐ Qualitative BCR/ABL(for diagnosis only) please specify below: - samples must be received within 24 hours of collection
   ☐ CML breakpoints      ☐ ALL breakpoints      ☐ CML & ALL breakpoints
☐ Quantitative BCR/ABL (for disease monitoring) – samples must be drawn in the morning and received in the lab before noon. DO NOT collect samples on Fridays. This sample will be referred out for testing.
☐ Other: _______________________________________________________________

Report to:  (Physician Information)

Name: _______________________________________________   Phone (___)___________   FAX: (___)___________
Address: __________________________________________________    City: _________________________________
Postal Code: ____________     CPSO#: _____________________    OHIP Billing #: ___________________

Signature: _____________________________________________________

Internal Lab Use Only:

Place Label Here