

CANCER GENETICS AND GENOMICS LABORATORY

MYELOID TESTING



BC CANCER 604-877-6000 EXT 67-2094
 DEPT. OF PATHOLOGY AND LABORATORY MEDICINE FAX: 604-877-6294
 ROOM 3307 - 600 WEST 10TH AVENUE MON-FRI 8:30AM-4:30PM
 VANCOUVER BC V5Z-4E6 WWW.CANCERGENETICSLAB.CA
CANCERGENETICSLAB@BCCANCER.BC.CA

ADDRESSOGRAPH OR PATIENT LABEL

PATIENT INFORMATION

Last Name		First and Middle Names	
Date of Birth (dd/mmm/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non Binary/Other/not disclosed		
PHN	BC Cancer ID	Cerner MRN	

REQUESTING PHYSICIAN

Name	MSC
Phone	Fax

SPECIMEN

Specimen Type <input type="checkbox"/> PB <input type="checkbox"/> BM Aspirate <input type="checkbox"/> MAA (<input type="checkbox"/> PB <input type="checkbox"/> BM) <input type="checkbox"/> CGL Specimen <input type="checkbox"/> Other _____	Originating Hospital Referring Lab Sample ID	Collection Date (dd/mmm/yyyy)
Myeloid Panel Special Instructions (BM EDTA only) Myeloid panel may detect variants associated with hereditary conditions. AML: BM report required for activation AML Panel and MRD Baseline require separate BM specimens MDS: BM report and cytogenetic report required for activation MPN: BM report required for activation		

Address

NOTE: PHYSICIAN SIGNATURE REQUIRED (BELOW)

COPY PHYSICIANS (ALL INFORMATION IS NECESSARY)

Name	MSC
Address	
Name	MSC
Address	
Name	MSC
Address	

REASON FOR TESTING / DIAGNOSIS / CLINICAL HISTORY (REQUIRED FOR TEST TO PROCEED)

CYTOGENETICS (FISH/KARYOTYPE)

PB(NaHEP) OR BM(MEDIA)

MOLECULAR

PB(EDTA) OR BM(EDTA)

MYELOID	Acute Myeloid Leukemia	<input type="checkbox"/> Karyotype (BM only) <input type="checkbox"/> FISH (specify probes): _____	New Diagnosis MRD Monitoring Relapsed / Refractory	All 3 specimens required prior to initiation of therapy: <input type="checkbox"/> Myeloid Panel / <i>FLT3</i> ITD & TKD (BM tube for DNA) <input type="checkbox"/> MRD Baseline (BM tube for RNA) <input type="checkbox"/> MRD Baseline (PB tube for RNA) <input type="checkbox"/> t(8;21) Restricted to patients being treated by intensive chemotherapy and/or eligible for HSCT <input type="checkbox"/> inv(16)/t(16;16) <input type="checkbox"/> <i>NPM1</i> <input type="checkbox"/> <i>FLT3</i> ITD & TKD (BM)
	Acute Promyelocytic Leukemia	<input type="checkbox"/> <i>PML::RARA</i> t(15;17) FISH <input type="checkbox"/> Karyotype (BM only)	<i>PML::RARA</i>	<input type="checkbox"/> MRD Baseline <input type="checkbox"/> MRD Monitor <input type="checkbox"/> query APL
	Chronic Myelogenous Leukemia	<input type="checkbox"/> <i>BCR::ABL1</i> t(9;22) FISH <input type="checkbox"/> Karyotype (BM only)	<i>BCR::ABL1</i>	<input type="checkbox"/> MRD Baseline <input type="checkbox"/> MRD Monitor <input type="checkbox"/> Kinase Domain Current therapy: _____
	Mast cell disease	<input type="checkbox"/> <i>FIP1L1::PDGFRA</i> (with eosinophilia)	<input type="checkbox"/> <i>KIT</i> D816V/F	
	Myelodysplastic Syndrome	<input type="checkbox"/> Karyotype (BM only)	<input type="checkbox"/> Myeloid Panel (BM, BM report, and cytogenetic report required)	
	Myeloproliferative Neoplasm	<input type="checkbox"/> <i>BCR::ABL1</i> t(9;22) FISH <input type="checkbox"/> Karyotype for MF or CMML (BM only)	Single-gene testing <input type="checkbox"/> query <i>JAK2</i> V617F MPN	Myeloid panel (BM, BM report required) <input type="checkbox"/> <i>JAK2</i> V617F negative MPN <input type="checkbox"/> <i>JAK2</i> V617F positive MPN (LEUK/BMT only)
OTHER	Chimerism		Pre-transplant assessment: <input type="checkbox"/> Donor <input type="checkbox"/> Recipient Post-transplant assessment Transplant Date: _____	
	Lymphoid and Myeloid neoplasm with Eosinophilia	<input type="checkbox"/> <i>FIP1L1/PDGFRB</i> <input type="checkbox"/> <i>PDGFRB</i> <input type="checkbox"/> <i>FGFR1</i> <input type="checkbox"/> <i>JAK2</i>		
	Multiple Myeloma	<input type="checkbox"/> FISH Panel (BM only for plasma cell separation)		

PHYSICIAN SIGNATURE (REQUIRED)	DATE
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LAB USE ONLY	PB NaHEP	PB EDTA	BM EDTA	BM Media	Other