

BM BX#

## BONE MARROW REFERRAL FORM

Please contact laboratory prior to sending sample to organize transport

### Patient Information:

Surname: \_\_\_\_\_  
 First name: \_\_\_\_\_  
 NHI: \_\_\_\_\_ Sex: \_\_\_\_\_  
 DOB: \_\_\_\_\_ Age: \_\_\_\_\_  
 Date and time collected: \_\_\_\_\_ Referring Doctor: \_\_\_\_\_

### Test Requested:

<b>CYTOGENETICS IBMC</b>	<b>FISH TESTING IBMF</b>
ACUTE LEUKEMIA	AML panel
CLL	MPD panel
MPD	MDS panel
MDS	CML
PANCYTOPENIA	ALL panel
CYTOPENIA	CLL panel
ANEMIA	T Lymphoma panel
GENERAL:	B Lymphoma Panel
	Myeloma panel Targeted plasma cell analysis
HAEMATOLOGICAL CLL CGH ARRAY	Other:

### Sample Requirements:

**Labeling** 2 unique identifiers on sample identical to the referral form

**Amount** Approx 1-2mL (paediatric: 1mL) of first draw  
**And**  
 6 Bone Marrow smear slides

**Collection** EDTA Vacutainer  
**Or** Heparin Vacutainer  
**Or** Sterile bijoux  
 (mix well to avoid container clotting)

**Transportation time** Sample should be received by IGENZ same day as sample collection.

**Transportation temperature** Ambient  
**DO NOT REFRIGERATE / FREEZE**

**Turn Around Time** 18 working days, urgent 5 days

**Special Instructions** Clotted bone marrow is unacceptable, however the laboratory will attempt to culture any sample received.

**ROUTINE**

**URGENT**

**Clinical information:** (Please provide a hematology report and any other relevant information required).

### Contact information:

IGENZ Ltd, Level 2, Quay Park Health, 68-70 Beach Rd, Auckland CBD, New Zealand  
[www.igenz.co.nz](http://www.igenz.co.nz) Phone +64 9 307 3981 Fax +64 9 307 3983

### Office use only:

Date and Time received: \_\_\_\_\_ By whom: \_\_\_\_\_  
 Comments: