# Bone Marrow Referral Form

Samples should be received by the laboratory within 48 hours of collection

igenz

| **Patient Information** | |
|---|---|
| Surname: | First name: |
| NHI: | Sex: |
| DOB: | Referring Doctor: |
| Date and time collected: | URGENT / Routine (Please circle) |

| **Test Requested (please tick)** |
|---|
| **Cytogenetic Analysis** |
| ☐ Conventional G-banded metaphase analysis |
| **FISH Analysis** |
| ☐ t(4;14), TP53 ☐ +/– t(14;16) ☐ +/– 1p/q |
| ☐ Myeloma panel [t(4;14), t(14;16), t(11;14), TP53, 13q14 and 1p/q] |
| ☐ TP53 (del17p) ONLY |
| ☐ CLL panel [del17p, del11q, del13q and chromosome 12] |
| ☐ Other (please specify probe or chromosomal region) |

| **Sample Requirements** |
|---|
| A minimum of 2 mL (paediatric 1 mL) heparinised bone marrow aspirate [first draw preferable] |
| All samples MUST be labelled with 2 unique identifiers identical to the referral form |
| Samples should be transported at ambient temperature |

| **Clinical Information:** |
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| **For office use only:** | |
|---|---|
| Date and time received: | By: |
| Sample received: | |