CANCER GENETICS REQUISITION – Hematologic Neoplasia

Hamilton Regional Laboratory Medicine Program

Juravinski Hospital
Clinical Genetics Laboratory - Room H2-19A
711 Concession Street, Hamilton, ON L8V IC3
Phone: (905) 521-2100 x73707
Email: geneticsmailbox@hhsc.ca

Patient Information

Clear Form

***Name** (print):
Surname, First Name

***DOB** (DD/MM/YYYY): ***Sex**: ☐ M ☐ F ☐ Other

***Health Card No.**:

*Mandatory Information. Specimen cannot be processed without this data.

Note: Specimen collection is NOT completed at this lab. Please proceed to any community lab for blood draw.

Reports To:

*Ordering Physician: _____

Address: _____

*Phone: _____ Fax: _____

Physician Signature: _____

Additional Copies To:

Name: _____

Address: _____

*Phone: _____

Fax: _____

Please see the HRLMP Laboratory Test Information Guide (LTIG) for complete sample requirements and testing information

https://ltig.hrlmp.ca/

Specimen Submitted:

Date of sample: (DD/MM/YYYY):

Time:

Location/Ward:

☐ Urgent ☐ Routine For all requests and inquiries: geneticsmailbox@hhsc.ca

☐ Bone Marrow (2-4 mL fresh aspirate in tubes as indicated below)

☐ Peripheral Blood (4-8 mL unless otherwise indicated. Max 16 mL if multiple tests requested)

All samples must be received in the laboratory within 48 hours of collection.

Ship at room temperature to address above. Do not freeze or spin.

DIAGNOSTIC TESTING Please take care in sending the correct sample type. Improper samples will lead to delays/cancellation.

MYELOID

*Testing will be performed upon confirmation of diagnosis

☐ **AML** (sodium heparin & EDTA bone marrow)
- Karyotype
- RNA Fusion Gene Panel*
- DNA Myeloid Panel/NGS*

☐ **MDS or MDS/MPN** (sodium heparin & EDTA bone marrow)
- Karyotype
- NGS*

For **suspected or confirmed MPN**, please use the MPN boxes below for testing.

OTHER

☐ **Karyotype Only** (sodium heparin bone marrow) *Please provide clinical information:*

_____

LYMPHOID

☐ **ALL** (sodium heparin & EDTA bone marrow)
- Karyotype
- RNA Fusion Gene Panel, *if dx confirmed*

☐ **MM** (sodium heparin bone marrow)
- FISH panel, *if dx confirmed*

☐ **CLL** (sodium heparin peripheral blood or bone marrow)
- FISH Panel, *if dx confirmed*

☐ **Hairy Cell Leukemia** (EDTA bone marrow or peripheral blood)
- BRAF codon V600 mutation

Lymphoma FISH (sodium heparin bone marrow)
- *If dx confirmed*
- ***Testing will NOT be performed unless probe(s) selected.***

☐ MYC (8q24) - Burkitt
☐ BCL2 (18q21.33) – Follicular/DLBCL
☐ BCL6 (3q27) – DLBCL
☐ ALK (2p23) – Anaplastic LCL
☐ MALT1 (18q21) – Marginal Zone
☐ CCND1 (11q13) – Mantle Cell

LYMPHOPROLIFERATIVE NEOPLASM

(EDTA bone marrow, peripheral blood or FFPE tissue curls)

☐ **B-cell rearrangement PCR**
☐ **T-cell rearrangement PCR**

CHIMERISM

☐ **Pre-BMT** (EDTA peripheral blood)
- ☐ *Donor*
  Donor for: _____
  - ☐ Same Sex Donor
  - ☐ Opposite Sex Donor
- ☐ *Recipient*
  DAY 0 = _____

☐ **Post-BMT** (16 mL EDTA peripheral blood)
No. days post-transplant: _____

SUSPECTED MYOPROLIFERATIVE NEOPLASM

☐ **JAK2 V617F and CALR** (EDTA peripheral blood or bone marrow), please specify†:
- ☐ **Unexplained abnormal blood counts:**
  - ☐ Leukocyte count ≥ 11 x 10^9/L
  - ☐ Hemoglobin concentration ≥ 160 g/L
  - ☐ Platelet count ≥ 400 x 10^9/L
- ☐ **Unexplained unusual site thrombosis**
- ☐ **Unexplained hepatosplenomegaly and/or leukoerythroblastic blood film**

☐ **CML - BCR::ABL1** (EDTA peripheral blood or bone marrow), please specify†:
- ☐ **Leukocyte count ≥ 11 x 10^9/L with left shift**
- ☐ **Platelet count ≥ 400 x 10^9/L with basophilia**

†Test requests without a relevant indication selected will not be processed. For other indications, please email the laboratory.

☐ **Karyotype** (sodium heparin peripheral blood or bone marrow)
☐ **Hypereosinophilia FISH Panel**, *if dx confirmed* (sodium heparin peripheral blood or bone marrow)
☐ **MPL** (EDTA bone marrow **ONLY**)
☐ **JAK2 Exon 12** (EDTA bone marrow **ONLY**)

CONFIRMED MYELOPROLIFERATIVE NEOPLASM

☐ **Confirmed MPN/MF**
- NGS Panel (EDTA bone marrow (preferred) or blood)**
  ** *NGS is available for confirmed MF or triple negative PV/ET*
- Karyotype (sodium heparin bone marrow (preferred) or blood)

** Please note, a pathology report is required to activate NGS. Please submit this with the requisition, or email to geneticsmailbox@hhsc.ca when available. NGS will not be activated for this indication without an appropriate report.

GENETICS LAB USE ONLY: Entered by: _____ Checked by: _____; BM or PB: ___ x ___ mL NaHep, __ x __ mL EDTA

Version date: CANGEN_HEMA_June2025

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FOLLOW-UP TESTING Testing performed based on previous findings ONLY

TREATMENT RESPONSE/DISEASE MONITORING

Testing will be completed if there are previous relevant diagnostic findings. **If genetic diagnostic findings were obtained externally, please include a copy of the report, or email report to geneticsmailbox@hhsc.ca.** If our laboratory does not have access to the relevant report, testing may be discontinued.

☐ **BCR::ABL1 p210 Follow-up**, Quantitative PCR (8 ml EDTA peripheral blood or 2-4 ml EDTA bone marrow)

☐ **FLT3 Follow-up** (EDTA bone marrow or peripheral blood)

☐ **NPM1 MRD - Type A Variant only** (EDTA bone marrow or peripheral blood)

☐ **NPM1 Follow-Up - Qualitative (Variants other than type A)** (EDTA bone marrow or peripheral blood)

☐ **Karyotype and/or molecular testing as indicated by diagnostic findings, please specify** (sodium heparin for karyotype *and/or* EDTA bone marrow or peripheral blood for molecular): _____

RELAPSE/PROGRESSION SUSPECTED

☐ **Karyotype as indicated by diagnostic finding:** _____ (sodium heparin bone marrow or peripheral blood)

☐ **Molecular testing (Qualitative RNA fusion gene by diagnostic findings)** (EDTA bone marrow or peripheral blood)
Fusion gene(s): _____

☐ **FLT3/NPM1 Relapse/Refractory** (EDTA bone marrow or peripheral blood)
Please note, NPM1 follow-up testing will only be completed if there are relevant diagnostic findings.

GENTICS LAB USE ONLY:

Reception

Entered by: _____

Data entry checked by: _____

Sample

BM or PB

___ x ____ mL NaHep

___ x ____ mL EDTA

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