HAMILTON REGIONAL LAB MEDICINE PROGRAM
Hamilton Health Sciences
Juravinski Hospital Site, Malignant Hematology
711 Concession Street
Hamilton, ON L8V 1C3
P: 905-527-4322 x42070 F: 905-575-2553

**REQUEST FOR FLOW CYTOMETRY TESTING**
**(Complete this form in full before sending)**

From (Referring Hospital): _____

Patient's Name: _____

Date of Birth: _____ Sex: _____
Day/Month/Year

**OHIN Number_____** **Version Code (important)_____**

Hospital I.D. _____ Lab Number _____

Requesting Physician – Name _____ Referring Number: _____

Result to be phoned to _____ faxed to _____

Date and Time Sample Taken: _____

**Specimen Type / Investigation Required:**

| | | |
|---|---|---|
| Bone Marrow | ☐ | Must include most recent CBC and 2 labelled unstained smears |
| Peripheral Blood | ☐ | Must include most recent CBC and 1 labelled unstained smear |
| PNH (PB only) | ☐ | Must include most recent CBC and 1 labelled unstained smear |
| EMA for HS (PB only) | ☐ | Must include most recent CBC and 1 labelled unstained smear |
| Lymph Node/Tissue | ☐ | Please specify site: _____ |
| Body Fluid | ☐ | Please specify site: _____ |
| Spinal Fluid | ☐ | Must include cell count (and differential if performed) |

**Relevant or Differential Diagnosis / Relevant Clinical Information:**

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## THIS COMPLETED FORM MUST:

**1) Accompany each specimen sent**

**2) Be faxed to 905-575-2553 at the time the specimen is sent**