LEUKAEMIC STUDIES REQUEST
(Cytogenetics/Molecular Genetics)

THE DOCTORS LABORATORY

Lab No: _____ Priority Code: _____

Surname: | | | | | | | | | | | | | | First Name: | | | | | | | | | | | | | |

Hospital No.: | | | | | | | | | | | | | | Date of Birth: D D M M Y Y Y Y

Consultant: _____ Gender: ☐ Male ☐ Female

Sample Type: _____ Sample WBC ($x10^9$/l): _____

Sample Date: _____ Sample Vol. (ml): _____

Date Received: D D M M Y Y Y Y Time Received: _____

Sample Comments: _____ Amount Sample/Culture: _____ Check: _____

Referral centre/hospital: _____

Full postal address: _____

_____

Tel No.: _____ Fax No.: _____

Referral reason/Clinical details: _____

_____

_____

Disease stage: _____ Treatment stage: _____

Karyotype analysis required? ☐ Yes ☐ No

FISH required? ☐ Yes ☐ No Probes: _____

RT-PCR Required? ☐ Yes ☐ No Gene Fusion: _____

SAMPLE REQUIREMENTS

In preservative-free heparin and RPMI medium

Preferred volume	**Peripheral Blood**	Adult: 10mls	Child: 2-5mls
	Bone Marrow	Adult: 5-10ml	Child: 2-5mls
Optimal time in transit	**Peripheral Blood:** 48hrs		
	Bone Marrow: 24hrs		