

# CANCER GENETICS REQUISITION – Hematologic Neoplasia



**Hamilton Regional  
Laboratory Medicine  
Program**

**Juravinski Hospital**

Clinical Genetics Laboratory - Room H2-19A  
711 Concession Street, Hamilton, ON L8V 1C3  
Phone: (905) 521-2100 x73707  
Email: [geneticsmailbox@hhsc.ca](mailto:geneticsmailbox@hhsc.ca)

**Patient Information**

\*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](mailto: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  ALK (2p23) - Anaplastic LCL

BCL2 (18q21.33) - Follicular/DLBCL  MALT1 (18q21) - Marginal Zone

BCL6 (3q27) - DLBCL  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  
Including CML**

**Molecular Panel**

- BCR::ABL1, JAK2, CALR (EDTA peripheral blood or bone marrow)

**Karyotype** (sodium heparin bone marrow)

**FISH** (PDGFRA, PDGFRB, FGFR1) (sodium heparin bone marrow)

**MPL** (EDTA bone marrow **ONLY**)

**JAK2 Exon 12** (EDTA bone marrow **ONLY**)

**CONFIRMED MYELOPROLIFERATIVE NEOPLASM**

**Confirmed MPN/MF** (pathology report required)

- 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)

**LAB USE ONLY:**

Version date: CANGEN\_HEMA\_Feb2024

**FOLLOW-UP TESTING \*Testing performed based on previous findings ONLY**

**TREATMENT RESPONSE/DISEASE MONITORING**

# Testing will be completed if there were relevant diagnostic findings.  
If genetic diagnostic findings were obtained externally, please include a copy of the report.

**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:**

(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:** \_\_\_\_\_

**FLT3/NPM1 Relapse/Refractory** (EDTA bone marrow or peripheral blood)

- NPM1 follow-up testing will be complete if there are relevant diagnostic findings.