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SickKids
THE HOSPITAL FOR SICK CHILDREN
Paediatric Laboratory Medicine

CYTOGENETICS LABORATORY
555 University Avenue
Room 3416, Hill Wing
Toronto, ON, M5G 1X8, Canada

Tel: 416-813-7200 x 1
Fax: 416-813-7732

(CLI# 99D1014032)

Patient Name:
Date of Birth (DD/MM/YYYY):
Legal Sex: Male Female Non-binary/U/X
Sex Assigned at Birth (if different): Male Female Unassigned
Gender Identity (if different): Male Female Non-binary/U/X
Parent's Name:
Address:

MRN#:
For Canada Only
Health Card #: Version:
Issuing Province

CYTOGENETICS ONCOLOGY

Referred-in Requisition

Testing is provided for medical purposes only and results are not intended for forensic use. The laboratory is not a forensically accredited laboratory.

SPECIMEN COLLECTION

DATE (DD/MM/YYYY)

TIME (HH:MM)

SHIPPING INSTRUCTIONS

- Send all specimens to Cytogenetics Laboratory, at the shipping address indicated above
- After hours, deliver to Rapid Response Laboratory, Room 3642
- Courier tracking information may be emailed to: cytogenetics.requests@sickkids.ca

SPECIMEN TYPE AND INFORMATION

- ☐ **Bone marrow aspirate** – 3 mLs in sodium heparin tube; transport at room temperature.
- ☐ **Peripheral blood** – 3-6 mLs in sodium heparin tube; transport at room temperature.
- ☐ **Solid tumour** – 2-3 mm^3 fresh tissue in transport medium or sterile PBS. Do not freeze. Transport ASAP.
- ☐ **Slides with 4 micron FFPE sections** (minimum 2 slides, for FISH testing only). Corresponding marked H&E slide requested if selected area to be analyzed,
- ☐ **FFPE scrolls: 10 X 10 m sections.** For OncoScan SNP Microarray testing only. Scrolls can be shipped at room temperature.
- ☐ **DNA extracted from FFPE tumour tissue.** For OncoScan SNP Microarray testing only.

Pathology Case Number - _____

INDICATION FOR TESTING

Haematopoietic

☐ New Leukemia ☐ Relapse ☐ MDS
☐ End of Induction ☐ Cytopenia ☐ Bone marrow involvement
☐ Follow up ☐ Anemia ☐ Other: _____

Solid tumour/lymphoma

Tumour type: _____

Site of biopsy: _____

TEST(S) REQUESTED

☐ **Process and hold pending pathology report/results** ☐ **KARYOTYPE**

FISH Leukemia/Lymphoma

ALL
- ☐ B-ALL FISH panel
- ☐ Ph-like (ABL1, ABL2, PDGFRß)
- ☐ Hyperdiploidy FISH probes
- ☐ ETV6-RUNX1 (TEL-AML1)
- ☐ BCR-ABL1
- ☐ KMT2A (MLL)
- ☐ TCF3 (E2A)
- ☐ CDKN2A (P16)
- ☐ IGH
- ☐ CRLF2
- ☐ ZNF384

Myeloproliferative
- ☐ BCR-ABL1
- ☐ PDGFRα
- ☐ PDGFRß

AML
- ☐ CBFB (inv(16), t(16;16))
- ☐ KMT2A (MLL)
- ☐ NUP98
- ☐ PML-RARα
- ☐ RUNX1/RUNX1T1 (AML1/ETO)
- ☐ Chromosome 7

Lymphoma
- ☐ ALK
- ☐ IRF4/DUSP22
- ☐ MYC (8q24)
- ☐ IGH/BCL2
- ☐ BCL6
- ☐ IGH/CCND1
- ☐ MALT1

☐ Other: _____

FISH Solid tumours

Aneurysmal bone cyst
Nodular fasciitis
- ☐ USP6

Alveolar rhabdomyosarcoma
- ☐ FOXO1 (FKHR)

Dermatofibrosarcoma protuberans
- ☐ PDGFB

Ewing's tumours
- ☐ EWSR1

Infantile fibrosarcoma
- ☐ ETV6

Liposarcoma
- ☐ DDIT3 (CHOP)
- ☐ FUS

Neuroblastoma
- ☐ MYCN

NUTM1-rearranged Neoplasia
- ☐ NUTM1

RCC/ASPS/PEComa
- ☐ TFE3

Rhabdoid
- ☐ INI1 (SMARCB1)

Synovial sarcoma
- ☐ SS18 (SYT)

Undifferentiated sarcoma
- ☐ CIC

Nervous system
- ☐ ALK ☐ CDKN2A

Astrocytoma
- ☐ BRAF

Ependymoma
- ☐ RELA

Medulloblastoma
- ☐ MYC ☐ MYCN ☐ MYB/CEP6

Oligodendroglioma
- ☐ 1p36/1q25 & 19q13/19p13

PNET
- ☐ C19MC

☐ Affymetrix OncoScan SNP Microarray
Note: For SNP microarray analysis on fresh frozen tissue (CytoScan), please use the SickKids Molecular Pathology requisition.

Referring Physician

Name (print) _____

Address _____

_____

Phone _____ Fax _____

Signature (required) _____

Copy of Report

Name (print) _____

Address _____

_____

_____

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Legal Sex: ○ *Male* ○ *Female* ○ *Non-binary/U/X*
Sex Assigned at Birth (if different): ○ *Male* ○ *Female* ○ *Unassigned*
Gender Identity (if different): ○ *Male* ○ *Female* ○ *Non-binary/U/X*
Parent's Name:
Address

MRN#

CYTOGENETICS ONCOLOGY
Billing Form

At your direction, we will bill the hospital, referring laboratory, referring physician, or a patient/guardian, for the services we render

- Invoices are sent upon completion of each test/service.
- Invoices are itemized and include the date of service, patient name, test name and charge.
- Contact SickKids' Cytogenetics Laboratory at 416-813-7200 x1 with billing inquiries.

How to complete the Billing Form:

- **Referring physician completes the appropriate section below to specify billing method.**
- **Send requisition and completed "Billing Form" with specimen.**

Section 1: Complete to have the healthcare provider billed:

Your Referring Laboratory's Reference #:_____

Billing address of hospital, referring laboratory, clinic, referring physician, or medical group: (if different from requisition):

Name: _____

Address: _____

City: _____ Prov/State: _____

Postal/Zip Code: _____ Country: _____

Section 2: Complete to have patient/guardian billed directly:

If you elect to have patient/guardian billed:

- *Patient/Guardian billing information below must be complete; otherwise, the healthcare provider will be billed.*
- *Please advise the patient/guardian to expect a bill from our laboratory.*
- *Provide us with patient's valid credit card information.*
- *Unfortunately, we cannot accept personal checks.*
- ***In this case, the patient/guardian is solely responsible for the charges.***

Send bill to (check one): ☐ Patient ☐ Guardian

Method of Payment (check one): ☐ American Express ☐ MasterCard ☐ Visa

Name as it appears on credit card:

Credit card #: _____ _____

Expiry date on credit card: _____

Signature of credit card holder (Required): _____

Mailing Address of Patient/Guardian (if different from requisition):

Name: _____

Address: _____

_____ Apt. #: _____

City: _____ Prov/State: _____

Postal/Zip Code: _____ Country: _____

Additional Contact Information:

Patient's phone # with area code:

_____

- or -

Guardian's phone # with area code:

_____