SickKids
THE HOSPITAL FOR SICK CHILDREN
Paediatric Laboratory Medicine

DIVISION OF HAEMATOPATHOLOGY
170 Elizabeth Street
Room 3642, Atrium
Toronto, ON, M5G 1E8, Canada
Tel: 416-813-7200 Fax: 416-813-5431

MRN:
Patient Last Name:
Patient First Name:
Birthdate (YYYY-MM-DD):
Gender: ☐ *Male* ☐ *Female*
Provincial Health Card #
Issuing Province:
Version:

Flow Cytometry

Referred-in Requisition

Specimen Type and Collection Requirements

- ☐ Bone Marrow (BM)
- ☐ Peripheral Blood (PB) - 2mL EDTA
- ☐ Body Fluid - Sterile Container (please specify):_____
- ☐ Tissue - RPMI (please specify):_____

Collection Date (YYYY-MM-DD)	**Collection Time** (HH:MM)

Ordering Physician *(please print)*:

Institution Name:_____

Contact Phone:_____

Contact Fax:_____

Clinical Information/Diagnosis

Test Requested (Please check one)

☐	Flow Cytometry Consultation Immunophenotyping (Leukemia/Lymphoma)	☐	Perforin Protein Expression
☐	Diagnostic MRD (B ALL only) *Send one tube (EDTA) of BMA (2mL) + 1 stained slide*	☐	Neutrophil Oxidative Burst Index
☐	Day 8 MRD (B ALL only) *Send one tube (EDTA) of blood (5-10 mL) at 4C + current CBC*	☐	CD45RA/RO
☐	Day 29 MRD (Follow-up or End of Consolidation) (B ALL only) *Send one tube (EDTA) of BMA (2mL) + 1 stained slide*	☐	Autoimmune Lymphoproliferative Syndrome (ALPS)
☐	Lymphocyte Subsets Enumeration (TBNK) ☐ TBNK and CD20	☐	CD34 Enumeration
☐	T Cell Subsets, CD3/CD4/CD8	☐	NK Degranulation Assay *(4mL peripheral blood needed)* **testing done Tuesdays only**
☐	Regulatory T cells		
☐	Platelet- Membrane Glycoprotein Expression	☐	Recent Thymic Emigrants
☐	B cell Subsets	☐	TCRV Beta

NOTE

Samples will only be accepted Monday to Thursday 8:00am to 5:00pm
Please send CBC results and one unstained blood and bone marrow slide for each patient

LABORATORY USE

_____-_____Date/time received (yyyy-mm-dd) / hh:mm Proceed with test ☐ Y ☐ N

Lab director_____

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BILLING FORM

How to complete the Billing Form: *(Completion of Billing Form NOT required for patients with an Ontario Health Card Number.)*

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

Option 1: Complete to have the Healthcare Provider billed:

Your Referring Laboratory's Reference #: _____

Billing address of hospital, referring laboratory:

Name:_____

Address: _____

City:_____Prov/State: _____

Postal/Zip Code: _____ Country: _____

Contact Name: _____

Contact Telephone #: _____

Option 2: Interm Federal Health Program (IFHP)

Submit a copy of the Interim Federal Health Certificate (Refugee Protection Claimant Document) with the photo and UCI# visible for coverage to be confirmed.

UCI# _____

ICD code *(lab use only)*:_____

Option 3: 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.*
- ***In this case, the patient/guardian is solely responsible for the charges.***

Relation to patient (check one): ☐ Patient ☐ Guardian/Parent

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

Name as it appears on credit card: _____

Credit card # : _____

Expiry date on credit card: _____

CVC#- found on back of card (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:

_____