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: ______________________________

Type of Specimen:

Bone Marrow	☐	(2 labeled unstained smears and CBC result)
Peripheral Blood	☐	(include most recent CBC and send 1 EDTA or heparinized tube)
PNH (PB only)	☐	(must be received within 48 hours)
Node, Tissue	☐	Please specify:______________________
Fluid	☐	Please specify:______________________

Investigation Required / Relevant Diagnosis / Clinical Information:

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THIS COMPLETED FORM MUST ACCOMPANY EACH SPECIMEN SENT

Revised: 10/29/2013