Haematology Referral Form

Patient Information

Surname: First name:

NHI: Sex at birth: ☐M ☐F

DOB:

Sample Details and Clinical Information

Specimen type: ☐blood ☐bone marrow ☐trephine other:

Date and time collected:

Referring laboratory reference:

Supporting clinical information:

Test/s Requested

Cytogenetic Analysis (Heparinised sample required)

☐ Conventional G-banded analysis

FISH Analysis: (Heparinised/EDTA sample required)

NB. Myeloma and CLL FISH is performed on a purified cell population.

☐ **Full myeloma panel**

☐ t(4;14) ☐t(14;16) ☐t(11;14) ☐TP53

☐ 1p/q ☐13q14

CLL panel

☐ del(17p) ☐del(11q) ☐del(13q)

☐ Chromosome 12

Other: (Please specify probe or chromosome region) _____

Molecular Testing (EDTA sample required)

☐ Microarray (Genome-wide analysis – SNP+CGH)

☐ JAK2 only

☐ JAK2 extended panel (JAK2, MPL, CALR, MYD88, IDH1, IDH2)

☐ MPL, CALR, MYD88, IDH1, IDH2 (dependent on JAK2 result – clinician directed)

Reporting Information

Referring Dr: NZMC#:

Contact #: Email:

Signature: Date:

Copy to Dr: Email:

Billing Information

Please indicate method of payment: (Invoice will be emailed to the referring doctor if not indicated)

☐ Invoice Health NZ: _____ Purchase Order # (required) _____

☐ Invoice Private Clinic: _____ Billing contact: _____

☐ Private patient to pay directly (*please attach IGENZ Consent and Payment Form*)

Please refer to our website for specific sample requirements: www.igenz.co.nz

ACCREDITED IANZ TESTING LABORATORY Nº 987

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