

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