

Legacy Laboratory Services
REQUEST FOR BONE MARROW ASSISTANCE

Prescheduled bone marrow assistance is available from the Laboratory:

- Monday-Friday 9:00 AM – 2:00PM
- For Emanuel Hospital same day or after-hours request, see Laboratory procedure BM.0106 Bone Marrow Collection Guidelines – Unscheduled – After hours

When scheduling Laboratory assistance for bone marrow collection, please complete all the following information:

Patient Name: _____

Sex: _____ Date of Birth: _____ Medical Record No.: _____

Authorizing Physician: _____ Phone: _____

Performing Physician: _____ Phone: _____

Location: _____ Date/Time of Procedure: _____

Clinical history or reason for bone marrow procedure: **THIS INFORMATION MUST BE PROVIDED**

- Indication for study: _____
- Prior treatment: _____

BONE MARROW STUDIES ORDERED:

Routine Orders:	Flow Cytometry Orders: Collect 1-3 mL EDTA (purple top)	Cytogenetics orders: Collect 4 mL sodium heparin (dark green top)
<input type="checkbox"/> Aspiration <input type="checkbox"/> Biopsy <input type="checkbox"/> Bilateral Biopsy	<input type="checkbox"/> Hold only for Flow Cytometry <input type="checkbox"/> Acute Leukemia <input type="checkbox"/> B-Cell Lymphoproliferative <input type="checkbox"/> Large Granular Lymphocytosis <input type="checkbox"/> Myeloma <input type="checkbox"/> Screening Panel-Monoclonality Blast <input type="checkbox"/> Sezary Syndrome <input type="checkbox"/> Other: _____ <input type="checkbox"/> No Flow studies requested	<input type="checkbox"/> Chromosome Studies (Karyotype) <input type="checkbox"/> Process and Hold for Chromosome Studies — Physician's phone number required. <input type="checkbox"/> No Cytogenetics testing requested
		Cytogenetics orders: Collect 1 mL EDTA (purple top)
		<input type="checkbox"/> Chromosomal Microarray (CGH)

Microbiology Orders: Preferred volume 0.5-5 mL	FISH Orders: Collect 2-4 mL EDTA (purple top) -or- sodium heparin (dark green top)
<input type="checkbox"/> Culture (C Blood) 1 FA Plus Blood Bottle <input type="checkbox"/> AFB, 1 SPS Tube (send to Referrals) <input type="checkbox"/> Fungus (C Fungus Blood) 1 FA Plus Blood Bottle <input type="checkbox"/> Other: _____ <input type="checkbox"/> No Microbiology requested	<input type="checkbox"/> MDS (Myelodysplastic Syndrome) <input type="checkbox"/> AML (Acute Myeloid Leukemia) <input type="checkbox"/> BCR/ABL1 [t(9;22)] (FISH only) <input type="checkbox"/> MM (Multiple Myeloma) <input type="checkbox"/> CLL (Chronic Lymphocytic Leukemia) <input type="checkbox"/> ALL (Acute Lymphocytic Leukemia) <input type="checkbox"/> Process and Hold only <input type="checkbox"/> Other: _____ <input type="checkbox"/> No FISH studies requested

Please fax form to applicable site:

Emanuel:503.413.2767 Mount Hood: 503.674.1277 Meridian Park: 503.692.2638 Good Samaritan: 503.413.7356 Salmon Creek: 360.487.1229