STEM CELL ASSAY LABORATORY
STEM CELL RESEARCH LAB
TERRY FOX LABORATORY
675 West 10th Avenue
Vancouver, B.C. V5Z 1L3
Telephone: (604) 675-8000, Local 7746
Fax: (604) 675-8149

ADDRESSOGRAPH :

Please note that the clinical utility of these tests is not yet established and these tests should be considered research.

☐ **HEMATOPOIETIC STEM CELL CULTURE**

☐ Blood & Marrow ☐ Blood ONLY ☐ Marrow ONLY

☐ **SERUM ERYTHROPOIETIN LEVEL**

Collected by	Time	Date

Date | Hospital

PHN | Unit number

Surname | Given name

Birthdate (mm.dd.yy) | Sex

Patient is: ☐ Inpatient ☐ Outpatient

WBC: _____

Plat: _____

Hgb: _____

1st Presentation: ☐ Yes ☐ No

Untreated: ☐ Yes ☐ No

Splenomegaly: ☐ Yes ☐ No

Cytogenetics requested: ☐ Yes ☐ No

DNA Analysis requested: ☐ Yes ☐ No

Working Diagnosis and brief clinical history:

INFECTIOUS BLOOD BORNE DISEASE:

POSITIVE specimens must not be sent unless prior permission has been obtained from Dr. Allen Eaves at the Terry Fox Laboratory (604) 675-8125

☐ Unknown

☐ Known Positive (_____)
known agent

Requesting Physician: _____ MSC # _____

Family Physician: _____ MSC # _____

Pathologist: _____ MSC # _____

Additional copies of results to be sent to: _____ MSC # _____

1. **PLEASE BOOK TEST IN ADVANCE AT (604) 675-8000 Local 7746 & ADVISE BY PHONE WHEN THE SPECIMEN HAS BEEN SENT**
2. **Return this requisition with specimen to the address above**
3. **Please send copies of Peripheral Blood (CBC), Marrow (Aspirate and Biopsy) and Cytogenetics/DNA Analysis Reports to facilitate QC/QA processes.**