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)**
☐ Aspiration ☐ Biopsy ☐ Bilateral Biopsy	☐ Hold only for Flow Cytometry ☐ Acute Leukemia ☐ B-Cell Lymphoproliferative ☐ Large Granular Lymphocytosis ☐ Myeloma ☐ Screening Panel-Monoclonality Blast ☐ Sezary Syndrome ☐ Other: _____ ☐ No Flow studies requested	☐ Chromosome Studies (Karyotype) ☐ Process and Hold for Chromosome Studies — **Physician's phone number required.** ☐ No Cytogenetics testing requested **Cytogenetics orders:** **Collect 1 mL EDTA (purple top)** ☐ 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)**
☐ Culture (C Blood) 1 FA Plus Blood Bottle ☐ AFB, 1 SPS Tube (send to Referrals) ☐ Fungus (C Fungus Blood) 1 FA Plus Blood Bottle ☐ Other: _____ ☐ No Microbiology requested	☐ MDS (Myelodysplastic Syndrome) ☐ AML (Acute Myeloid Leukemia) ☐ BCR/ABL1 [t(9;22)] (FISH only) ☐ MM (Multiple Myeloma) ☐ CLL (Chronic Lymphocytic Leukemia) ☐ ALL (Acute Lymphocytic Leukemia) ☐ Process and Hold only ☐ Other: _____ ☐ 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

Title (no LTR): Bone Marrow Request for Assistance Form

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