Haematology Laboratory University Hospital Waterford
Bone Marrow Aspirate
Request Form

All sections of the form must be completed.
Telephone: 051 842475
www.hse.ie/go/wrhlab

Section A: Patient Details

Chart No.			
Surname:		**Male:**	**Female:**
First Name:		**D.O.B.**	DD / MM / YEAR
Address:			

Section B: Clinician Details

Consultant Haematologist		**Consultant's Code:**
Name & Bleep No of doctor taking the sample		**Doctor's Signature:**

Section C: Sample Details

Date & Time samples taken DD / MM / YEAR **Time:** 00:00

Section D: Clinical Details – include treatment details as relevant

Diagnosis:

Section E – Investigations required

Appropriate sample & relevant form should be completed including green BLOOD SCIENCES form

Investigation – Tick box to indicate	Samples Required	Request Form Required
BMA Morphology □	BMA Slides	UHW BMA form **(p1)**
Immunophenotyping □	1 x BMA sample in RPMI & Heparin	UHW Immunophenotyping Referral form **(p2)**
Karyotyping / Cytogenetics □	1 x 5ml BMA sample in 9ml Lithium Heparin vial	MLL lab Referral form **(p3&4)**
Molecular Studies □	1 x BMA sample in RPMI & Heparin	SJH CMD Referral form * **(p5)**
Multiple Myeloma FISH □	1 x BMA sample in RPMI & Heparin	Eurofins Biomnis lab Referral form **(p6)**
Myeloid NGS □	1 x BMA sample in RPMI & Heparin	SJH CMD form (Other section - **(p5)**

*** External sample referral as follow :**

- CLL FISH to Crumlin Cytogenetics, p53 & IGHV mutation screen to SJH CMD
- Use MLL forms for any molecular testing if not available at SJH CMD

Bone Marrow Trephine sample – Send sample and a Histology request form to UHW Histology Lab

Section F – Transport requirements

Standard Courier □
Taxi □ **for URGENT BMAs only, indicate taxi is authorised by consultant -** □

Haematology Laboratory University Hospital Waterford
Flow Cytometry / Immunophenotyping Referral Form to St James's Hospital
Telephone: 051 842475

All sections of the form must be completed.

Section A: Patient Details - use a demographic sticker, if available																		
Chart No.																		
Surname:																	**Male: □**	**Female: □**
First Name:														**D.O.B.**			DD / MM /YEAR	
Address:																		
Ward/OPD																		

Section B: Clinician Details		
Consultant		**Consultant Code:**
Name of doctor taking the sample		**Doctor's Signature:**

Section C: Sample Details:
Date & Time samples taken DD / MM / YEAR 00:00
Indicate sample type: Peripheral Blood □ Bone Marrow Aspirate □ CSF (Use Tranxfix tube) □ Other (specify) □
Section D: Clinical Details – include treatment details as relevant

Section E: Indicate Investigation required	
□ B, T, NK cell count (Lymphocyte subsets)	**□ PNH Screen**
□ CD4/CD8	**□ EMA for RBC membrane defect (HS)**
□ Acute Screen	**□ Other – Specify:**
□ B-cell Lymphoproliferative	**□ Enclose 2 unstained slides**
□ T-cell Lymphoproliferative	

Section F – Transport requirements
Standard Courier ☐
Taxi ☐ **for URGENT samples only, indicate taxi is authorised by consultant -** ☐

MLL Münchner Leukämielabor GmbH
Max-Lebsche-Platz 31
81377 München
Postfach 20 11+ 53, 80011+ München

T: +1+9 (0)89 99017-0
F: +1+9 (0)89 99017-111
info@mll.com
www.mll.com

MLL MVZ GmbH
Medizinisches Versorgungszentrum
für Innere Medizin, Hämatologie und
Internistische Onkologie

T: +1+9 (0)89 99015-0
F: +1+9 (0)89 99015-111
info@mll-mvz.com
www.mll-mvz.com

Akkreditiert:
DIN EN ISO 15189 und
DIN EN ISO/IEC 17025

Akkreditiert:
DIN EN ISO 15189

Prof. Dr. med. Dr. phil. Torsten Haferlach, Prof. Dr. med. Wolfgang Kern, Prof. Dr. med. Claudia Haferlach

Request form

Material Receiption: Monday to saturday, sunday after telephone registration

Shipping: If possible by 24h Express, for shipping on Friday please mark **Saturday delivery.**

Required test material:
- **Chromosome analysis**: 5 ml **heparin** bone marrow (500 I.E. Hep./ml bone marrow, **no** EDTA/citrate, in exceptional cases heparin blood)
- **Cytomorphology**: 4-6 unstained smears of bone marrow and blood each (anticoagulant **EDTA** or **citrate, no** heparin)
- **Molecular genetics/Immunophenotyping**:

10 – 15 ml bone marrow/periphal blood each (EDTA/heparin/citrate)

Name, first name:

Date of Birth: Sex: female male

Address:

Frame for patient label

Material: ○ Bone marrow (10 ml) ○ Periphal blood (20 ml)

Date of material withdrawal:

Time of material withdrawal:

Number of bone marrow smears:

Number of periphal blood smears:

Initial diagnosis Follow-up

Study:

Analysis:
- ○ ~~Cytomorphology~~
- ○ ~~Immunophenotyping (Flow cytometry)~~
- ○ Chromosome analysis (Cytogenetics)
- ○ ~~FISH~~
- ○ ~~Molecular genetics (PCR, Mutation analysis, NGS)~~

~~or/and~~

○ ~~(step-by-step) diagnostics according to guidelines/recommendation of the professional societies~~

Laboratory Values:

Blood count		**Differential blood count**			
Leukocytes:	/µl	Myeloblasts:	% Band neutrophils:	% Monocytes:	%
Hemoglobin:	g/dl	Promyeloblasts:	% Mature neutrophils:	% Lymphocytes:	%
Thrombocytes:	/µl	Myelocytes:	% Eosinophiles:	%	
(Required specification)		Metamyelocytes:	% Basophiles:	%	

(Suspected) Diagnosis, other pathological findings:

Therapy (incl. previous radio-/ chemotherapy):

Requesting physician (stamp) with telephone number and fax number:

Please enclose signed patient consent form! Version: 27.02.2023 Page 1

Please send the enclosure to:

MLL MVZ GmbH
Postfach 20 14 53
80014 München

Telefon: +49 (0)89 99017-0
E-Mail: info@mll.com

Patient Consent – MLL Research Projects

I have been informed of the research activities of MLL through MLL's information sheet on data processing and the use of biomaterial as well as the additional information available at www.mll.com. I would like to support the research activities of MLL and consent to the use of my excess biomaterial for research purposes. Based on the information of MLL, I understand that I am donating my biomaterial for research purposes and will not share in any financial proceeds from the research using my biomaterial or health data.

Additional (please tick the box, if desired):

☐ If MLL gains any new medical knowledge about me, I agree that MLL will inform me of this knowledge without prior request.

I may revoke my consent and agreement to be contacted in the case of new knowledge at any time and also separately with effect for the future. Notice of my revocation may be sent by mail to MLL Münchner Leukämielabor GmbH, Max-Lebsche-Platz 31, 81377 Munich, electronically using the email address info@mll.com or by fax to 089-99017111.

Date, Signature: _____

First name, Last name: Date of birth:

Street: Postal code, City:

Cancer Molecular Diagnostics, LabMed Directorate, St. James's Hospital, Dublin 8
Tel: 01-4103576/3567 01-4162062 Fax: 01-4103513
Email: cmd@stjames.ie

CANCER MOLECULAR DIAGNOSTICS REQUEST FORM

PATIENT IDENTIFICATION	REQUESTOR DETAILS
Surname:	Referring Consultant & Report Address:
First Name:	
Address:	
Sex: M ☐ F ☐ U ☐	2nd Referring Consultant & Report Address:
DOB:	
Hospital No:	
Health Insurance Status: Public ☐ Private ☐	

SAMPLE DETAILS:

Date of Sample:	External Ref No:	CMD No:

Sample Type: Peripheral Blood ☐ Bone Marrow Aspirate ☐ Fresh/Frozen Tissue ☐
Paraffin Section ☐ Paraffin Block ☐ Buccal Swab ☐

Other (please specify):

Biopsy/section site details:

DIAGNOSIS / CLINICAL DETAILS :

REQUIRED TEST:

Solid Tumour Requests:

Colorectal Cancer Panel ☐
Lung Adenocarcinoma Panel ☐
GIST Panel ☐
Melanoma Panel ☐
cfDNA EGFR T790M mutation ☐

See Solid Tumour service user handbook for full panel details

Lymphoid (mature) Requests:

B-cell clonality screen ☐
T-cell clonality screen ☐
BCL1-JH t(11;14) ☐
BCL2-JH t(14;18) ☐
IgVH mutation status ☐
TP53 Mutational Analysis ☐

Please provide immunophenotype and histology report

Chimerism:

PB/BM Unfractionated ☐
CD3+ Fractionated ☐
Provenance Analysis ☐

Bank:
DNA ☐ RNA ☐

Myeloid/Acute Leukaemia Requests:

MPN:

BCR-ABL1 (p210) Qualitative ☐
BCR-ABL1 (p210) Quantitative ☐
ABL Kinase Domain Mutation ☐
JAK2 V617F ☐
CALR ☐
MPN Panel ☐

AML:

FLT3-ITD ☐
NPM1 ☐
RUNX1-RUNX1T1 ☐
CBFB-MYH11 ☐
PML-RARA ☐

ALL:

BCR-ABL1 (p190/p210) Qualitative ☐
BCR-ABL1 (p190/p210) Quantitative ☐

Other (Clinical Trial/Research Use Only) Please state:

eurofins | Biomnis

Test request form
Hematologic Malignancies

Specialised cytology and immune cell typing (flow cytometry) Cytogenetics and Molecular Biology

Eurofins Biomnis Ireland, Three Rock Rd,
Sandyford Business Estate, Dublin 18, Email:
sales@eurofins-biomnis.ie, Tel: 01 295 8545

Laboratory code

PATIENT DETAILS

First name(s): .....

Surname: .....

Date of birth: L_L_J L_L_J L_L_L_L_J

Address: .....

.....

City: ..... Post code: .....

Country: .....

Tel.: ..... Gender: ☐ F ☐ M

REQUESTING PHYSICIAN

First name(s): .....

Surname: .....

Address: .....

City: ..... Post code: .....

Country: .....

Tel.: .....

Fax: .....

E-mail: .....

REQUIRED TESTS AND SAMPLE TYPES

CYTOLOGY

☐ **Blood**: *complete blood count (1 unstained film)*
☐ **Bone marrow**: *Bone marrow aspirate (3-6 unstained slides)*
☐ **Lymph node**: *Adenogram (unstained films)*
☐ **Other**: .....

IMMUNOLOGICAL TYPING

☐ **Blood:** *(1 EDTA or Heparin tube + 1 unstained film)*
☐ **Bone marrow:** *(1 EDTA or Heparin tube + 1 unstained film)*
☐ **Other**: .....

CYTOGENETIC

☐ **Conventional (karyotype)**

[X] **Molecular (FISH)** - *Please specify:* **Myeloma: FISH only on sorting plasma Cells**
☐ **Blood** *(1 Heparin tube)* ☐ **Bone marrow** *(1 Heparin tube)* ☐ **Lymph node**