BONE MARROW CYTOGENETICS

Genetic Laboratory
Haematology Unit, Cancer Research Centre
Institute for Medical Research
Jalan Pahang
50588 Kuala Lumpur, Malaysia

Phone : 03-2616 2711
Fax : 03-2616 2530
Website : http://www.imr.gov.my

Specimen requirements:

1. ***Chromosome analysis***: Please send at least 2mL of FIRST bone marrow aspirate or blood ***(white blood count is >10,000 WBC/mL and at least 20% blasts)*** into sterile transport medium available from Genetic Laboratory. Transport as soon as possible. Protect from extreme heat and freeze.

2. ***Chromosome breakages***: An appointment is necessary for the performance of this analysis. Please contact the Genetic Laboratory for further instruction. Please send 10mL peripheral blood in sterile lithium heparin tube. A control sample, matched for age and sex is required.

FOR GENETIC LAB USE ONLY

Genetic No. : BM
Serial No. :

Previous Cytogenetic Result:

PATIENT INFORMATION

1. Patient Name :		2. IC No. :
3. Age :	4. Ethnicity : ☐ Malay ☐ Chinese ☐ Indian ☐ Others; Please specify: _____	5. Gender : ☐ Male ☐ Female
6. Clinical History :		7. Address to send test report :

CLINICAL DIAGNOSIS

- ☐ Acute Lymphoblastic Leukaemia
- ☐ Acute Myeloid Leukaemia
  FAB type: _____
- ☐ Chronic Myeloid Leukaemia
  ☐ Chronic phase ☐ Accelerated phase
  ☐ Blast phase
- ☐ Myeloproliferative Neoplasms
- ☐ Myelodysplastic Syndrome
- ☐ Myelodysplastic/Myeloproliferative Neoplasms
- ☐ Multiple Myeloma
- ☐ Lymphoma
  Please specify: _____
- ☐ Chronic Lymphocytic Leukaemia
- ☐ Aplastic Anaemia
- ☐ Others: _____

DISEASE STATUS

- ☐ New Case
- ☐ Marrow Assessment
- ☐ Remission
- ☐ Relapse
- ☐ Post-Stem Cell Transplant
  Sex of Donor
  ☐ Male ☐ Female

SPECIMEN INFORMATION

Date Drawn : ___/___/_____ Time : _____
Date Sent : ___/___/_____ Time : _____

Specimen Type:

- ☐ Bone Marrow Aspirate
  Volume of aspirates: _____mL
- ☐ Peripheral Blood
  WBC count: _____WBC/mL % Blast: _____

TEST REQUESTED

- ☐ Chromosome Analysis
- ☐ Chromosome Breakages
- ☐ FISH
  ☐ BCR/ABL ☐ PML/RARA

FISH analysis: Unless otherwise specified, this test will be done on selective cases under the discretion of the Laboratory Supervisor.

Official stamp of Requesting Doctor:

Name & Signature

Date: