Clinical Genomics Laboratory
5850/5980 University Ave, PO Box 9700
Halifax, NS B3K 6R8
Phone: (902) 470-6504
Fax: (902) 470-7466
Email: clinicalgenomics@iwk.nshealth.ca

IWK Health

For additional up-to-date testing information and our most current requisitions, please visit our website: **http://www.iwk.nshealth.ca/clinical-genomics/**

ONCOLOGY CYTOGENETIC KARYOTYPE TESTING

Hours of Operation: Monday to Friday: 0800-1700. After hours call: 902-470-8289

Patient Information

Name *(LAST, FIRST MIDDLE)* :

DOB *(dd/mmm/yyyy)* :

Health Card #: Prov of Residence:

Hospital #:

Site Visit # (IWK patients only):

Sex Assigned at Birth: Legal Gender:

Indicate, if applicable:

☐ Patient has had a previous karyotype
NOTE: If performed at an external laboratory, please attach report or specify karyotype in *Additional Information* section

Testing Category

Required:

☐ New diagnosis (known or suspected) ☐ Follow-up
☐ Relapse (known or suspected) ☐ Remission (known or suspected)

Reason for Testing: Check all that apply

Bone Marrow Transplant:

☐ Post-BMT: Autologous ☐ Pre-BMT (baseline)
☐ Post-BMT: Allogeneic- **specify donor sex** _____ ☐ Donor screen

Known or Suspected Hematological Disorder:

☐ ALL: specify B-cell/T-cell/unknown _____
☐ AML: specify subtype, if known _____
☐ Acute Leukemia- unknown subtype
☐ CLL
☐ CML
☐ CMML
☐ Lymphoma: specify type, if known _____
☐ MDS
☐ MPN: specify type, if known _____
☐ Plasma cell neoplasm/Multiple Myeloma
☐ Other: specify _____

Non-Specific Findings:

GENERAL FINDINGS	CYTOPENIA	PLASMA CELL INDICATIONS
☐ Eosinophilia	☐ Anemia	☐ Amyloidosis
☐ Thrombocytosis	☐ Leukopenia	☐ IgA
☐ Splenomegaly	☐ Neutropenia	☐ Kappa Monoclonal protein
☐ Macrocytosis	☐ Thrombocytopenia	☐ IgG
☐ Leukocytosis	☐ Pancytopenia	☐ IgM MGUS
		☐ Plasmacytoma

☐ Circulating blasts: specify % _____
☐ Marrow failure syndrome: specify _____
☐ Other: specify _____

Ordering Health Care Provider Information

Name:
Office/Institution:
Phone #:
Email:
Fax #:
(Required)

Signature (Required): _____ _____
Health Care Provider Date *(dd/mmm/yy*

Copies to Additional Health Care Providers

Genetic Counsellor: Phone #:
Facility: Fax #:

Health care provider: Phone #:
Facility: Fax #:

Additional Information

Solid Tumours:

☐ Small round cell tumour: specify_____
☐ Non-small round cell tumour: specify_____
☐ Tumour, unknown subtype

Sample Type

☐ Bone marrow - Green NaHep 2mL
☐ Bone core trephine biopsy
☐ Peripheral blood - Green NaHep 4mL **NOTE:** only if circulating blasts >10%. Specify %____
☐ Lymph node: specify source_____
☐ Tumour: specify source_____

Collection Date/Time:
Collection Facility: Collector Initials:

Please see reverse page for collection information and shipping instructions

Rev:May2023

Clinical Genomics Laboratory
5850/5980 University Ave, PO Box 9700
Halifax, NS B3K 6R8
Phone: (902) 470-6504
Fax: (902) 470-7466
Email: clinicalgenomics@iwk.nshealth.ca

For additional up-to-date testing information and our most current requisitions, please visit our website: **http://www.iwk.nshealth.ca/clinical-genomics/**

ONCOLOGY CYTOGENETIC KARYOTYPE TESTING

Hours of Operation: Monday to Friday: 0800-1700. After hours call: 902-470-8289

Sample Requirements for Cytogenetic Oncology Karoytype Testing

Bone Marrow: Collect a minimum of 2mL bone marrow in green NaHep. Do not centrifuge or freeze specimen. Ship to the laboratory at room temperature within 24 hours.

Bone core trephine biopsy: Collect 1" bone core (if possible) into a sterile specimen jar containing sterile culture media or saline. Do not freeze. Ship to the laboratory at room temperature within 24 hours.

Peripheral Blood: (NOTE: cytogenetic oncology testing is only possible on peripheral blood if there are ≥10% circulating blasts). Collect 4mL peripheral blood in green NaHep IWK meditech CG. Do not centrifuge or freeze specimen. Ship at room temperature within 24 hours.

Lymph Node/Tumour: Collect a $1cm^3$ specimen (where possible) fresh tumour/lymph node tissue into a specimen jar containing sterile saline or media. Do not freeze. Send to the laboratory at 4˚C within 24 hours.

Information about Cytogenetic Oncology Genetic Testing

Information to be discussed with patient by Healthcare Provider (note: consent for pathology specimens is included under the autopsy consent). Additional information regarding indications for testing, test procedures, test limitations and turnaround times can be found on our website at **https://www.iwk.nshealth.ca/clinical-genomics**.

General Information about Genetic Testing

1. Testing cannot detect every genetic abnormality. Therefore, a normal test result does not rule out all possible genetic conditions.
2. Correlation with clinical information may be required for accurate interpretation. Correct interpretation of results depend on accurate clinical findings, family relationships and other laboratory data provided.
3. This test might reveal:
   a. Variants of uncertain significance (VUS). These variants may or may not be related to the patient's phenotype or disease.
   b. Structural rearrangements, mosaicism, or full or partial aneuploidy which may have reproductive implications for this individual or related family members.
4. Complete interpretation of test results may require additional follow-up testing on other family members.
5. Test results are confidential, but may be used without identifying information for interpretation of testing for family members.
6. When available, genetic testing will be performed at the IWK Clinical Genomics Laboratory (CGL). When testing cannot be performed at CGL, testing may be referred out to an external laboratory.
7. Results from testing may be submitted to clinical databases anonymously as needed (with all identifying information removed). These clinical databases are used by the laboratory in order to assist in accurate interpretation of results.
8. Genetic counselling through Maritime Medical Genetics Service (MMGS) is available upon request: fax a referral to their department at 470-8709 or phone 902-470-8754 to request the appropriate forms.

SAMPLE STORAGE

Fixed Cell Pellet Retention:

- Following testing, fixed cell pellet from all bone marrow, bone core and peripheral blood specimens will be retained for a minimum of 6 months (fixed cell pellets from pediatric patients will be retained for a minimum of 25 years). Any additional testing of the sample will require a new requisition formally requesting the additional testing.
- When testing is complete, the laboratory may anonymize and use some of the residual sample or genetic data to improve and develop new testing. Unexpected genetic findings unrelated to the testing indication will not be reported.