

BONE MARROW BIOPSY REQUEST FORM



Email completed referral to bonemarrow@labtests.co.nz

REFERRER TO COMPLETE			
NHI:	Patient Surname:	Given Name:	
DOB:	Sex:	Address:	
Patient Phone number:		Patient email:	
Requesting Doctor:			Requestor Code:
Requesting Doctor address			NZMC:
Copy to			Ref:
Clinical Details:			Anticoagulant or anti-platelet therapy? <input type="checkbox"/>
			Specify Drug(s): _____
Doctors signature:			Date:

LABORATORY USE ONLY			
Collection Date:	Collection Time:	Collected by (sign):	Smear Prep/stained by (sign):
<input type="checkbox"/>	? Anticoagulant or anti-platelet therapy	<input type="checkbox"/>	? Suitability for Pentrox
<input type="checkbox"/>	Diagnostic / Staging bone marrow performed by Dr _____		
Site of Biopsy:	RIGHT <input type="checkbox"/>	LEFT <input type="checkbox"/>	

Bone Marrow Aspirate <input type="checkbox"/>			
<input type="checkbox"/>	Iron stain		
Samples Taken	Hold	Samples to be Sent (Specify Tests Required)	
<input type="checkbox"/>	Cell Markers / Immunophenotyping	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Chromosome Analysis – Bone marrow	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Molecular Haematology	<input type="checkbox"/>	<input type="checkbox"/>
Bone Marrow Trepine <input type="checkbox"/>			

CLINICAL DETAILS		
Pathologist's name and signature	Contact Number	Date:

Booking CheckList <input type="checkbox"/> Patient on any anticoagulant or anti- platelet drug <input type="checkbox"/> Booking confirmed via Phone <input type="checkbox"/> Booking confirmation Emailed <input type="checkbox"/> Entered in SB Calander <input type="checkbox"/> Entered in Archiving log	Booking Details Date: / / Time: Sign: _____
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