Labtests

BONE MARROW BIOPSY REQUEST FORM

PLACE BAR CODE HERE
(LAB USE ONLY)

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:**	**Eligible for DHB funding:** ☐ **ELIGIBLE** ☐ **UNELIGIBLE: Quote required**
Copy to:		**NZMC:**	**Consent obtained for NGS or DNA storage?** ☐ **YES** ☐ **NO**
Clinical Details:			**Anticoagulant or anti-platelet therapy?** ☐ **YES** ☐ **NO** **Specify Drug(s):** _____
Doctors signature:			**Date:**

LABORATORY USE ONLY			
Site of Biopsy: **RIGHT** ☐ **LEFT** ☐			
Collection Date:	**Collection Time:**	**Collected by (sign):**	**Smear Prep/stained by (sign):**

Bone Marrow Aspirate			***CDC Registration Code:***	***BM***
			Sendaway codes:	
Iron stain (aspirate only)	☐			
Samples Taken	**Hold**	**Samples to be Sent (Specify Tests Required)**		
Cell Markers / Immunophenotyping	☐	☐		
Chromosome Analysis – Bone marrow	☐	☐		
Molecular Haematology	☐	☐		

Bone Marrow Trephine	

Pathologist's name and signature	**Contact Number**	**Date:**

Booking CheckList

☐ Patient on any anticoaguant or anti- platelet drug (YES / NO) : _____

☐ Booking initiated via Phone / TXT ☐ Entered in SB Calander

☐ Booking confirmation Emailed ☐ Entered in Archiving log

Booking Details

Date: / /

Time:

Sign:_____