

Bone Marrow Transplant Testing Requisition

Scanning Label or Accession # <i>(lab only)</i>

Patient	PHN	Expiry: _____	Date of Birth <i>(dd-Mon-yyyy)</i>		
	Legal Last Name		Legal First Name		Alternate Identifier
	Middle Name	Preferred Name	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Phone
			<input type="checkbox"/> X Non-binary/Prefer not to disclose		
Address		City/Town	Prov	Postal Code	
Provider(s)	Authorizing Provider Name <i>(last, first, middle)</i>		Copy to Name <i>(last, first, middle)</i>	Copy to Name <i>(last, first, middle)</i>	
	Address		Phone	Address	
	CC Provider ID	CC Submitter ID	Legacy ID	Phone	
	Clinic Name		Clinic Name	Clinic Name	
Collection	Date <i>(dd-Mon-yyyy)</i>	Time <i>(24 hr)</i>	Location	Collector ID	

Collection Protocol *(Deliver to: ProvLab, 3030 Hospital Drive NW, Calgary, AB)*

Collect

Routine BMT Testing - 2 SST tubes

Potential Allogeneic Transplant Recipient *(Enter in Order Comment)*

Last Name	First Name	Initial
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Patient Status

Routine BMT Testing

Allogeneic Recipient Allogeneic Donor Autologous

Test Request and Details of order

<p>Routine BMT Testing</p> <p><input type="checkbox"/> BM TRANS1 (CMV IgG included) <i>Tests included in this panel: HIV, HTLV I/II, Hepatitis C, Hepatitis B surface antigen, Hepatitis B Core Total, Syphilis, Varicella-Zoster IgG, Epstein-Barr virus, Herpes Simplex IgG, CMV IgG</i></p> <p><input type="checkbox"/> BM TRANS2 (CMV not included) <i>Tests included in this panel: HIV, HTLV I/II, Hepatitis C, Hepatitis B surface antigen, Hepatitis B Core Total, Syphilis, Varicella-Zoster IgG, Epstein-Barr virus, Herpes Simplex IgG</i></p>	<p><input type="checkbox"/> CMV IgG PROV <i>Test included: CMV serology for IgG for initial screening</i></p> <p><input type="checkbox"/> EBV AB PROV <i>Test included: Epstein-Barr viral serology</i></p> <p><input type="checkbox"/> HSV IgG PROV <i>Test included: Herpes simplex viral serology</i></p> <p><input type="checkbox"/> VZV IgG PROV <i>Test included: Varicella-zoster viral serology</i></p>
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