# MOLECULAR DIAGNOSTIC TEST REQUEST FORM – BCR-ABL MUTATION ANALYSIS

**Lab. No:**

| **PATIENT'S PARTICULARS** | | | |
|---|---|---|---|
| **Name:** | | **RN:** | **IC no:** |
| **Sex:** | **Age:** | **Date of birth:** | **Hosp/ Ward:** |
| **Address:** | | | |
| **DIAGNOSIS:** | | | |

**HISTORY OF PRESENTING ILLNESS**

**1) Date of diagnosis:**

**2) Initial presentation:**

**3) Current presentation:**

**4) Physical examination (current):**

**5) Disease progress:**

**6) Treatment:**

**TREATMENT RESPONSE**

Cytogenetic response:

Molecular response:

**HAEMATOLOGICAL PARAMETERS**

| | |
|---|---|
| Total White Blood Cell Count | ($x10^9$ /L) |
| Haemoglobin | (g/dL) |
| Platelet Count | (($x10^9$ /L) |
| Blast in PBF | % |

**Name and stamp of specialist/Consultant:**

**Contact No. :**
**Email:**

| **PROCESSING LAB (For internal use only)** | | |
|---|---|---|
| **Date received:** | **Time received:** | **Received by:** |
| **Sample accepted / rejected (specify the reason):** | | |
| **Sample processed by (name and stamp):** | | |