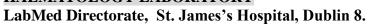
Bone Marrow Aspirate Examination Request Form HAEMATOLOGY LABORATORY

Date and Time Received in SJH Lab:





FOR SJH LABORATORY USE ONLY. PLEASE AFFIX SPECIMEN NUMBER BARCODE LABEL HERE

Tel.: 01 4162048/4162394 www.stjames.ie										
PATIENT DETAILS:										
Surname:										
Forename:										
Date of birth:	/									
MRN:										
Patient's Address:										
CLINICAL DETAILS: Include treatment details as relevant.										
Has the patient attended SJH previously? Yes No SJH MRN:										
Patient's Consultant in SJH:										
Please forward a copy of the most recent FBC, flow cytometry and cytogenetics reports and any other relevant details.										
REASON FOR REFERRAL:										
Pre-transplant Other please specify below:										
REFERRING HOSPITAL AND SAMPLE DETAILS:										
Referring Hospital Name:										
Requesting Consultant:						_ Contac	ot de	ataile•		
requesting constitution										
Referring Laboratory No.	Date of Collection		Sample Type (BMA/Blood Film)) No	No. of slides		Stained		Unstained
	•									•