Kingdom of Saudi Arabia
Ministry of Health
Jeddah First Health Cluster
Jeddah Regional Laboratory

تجمع جدة الصحي الأول
مختبر جدة الإقليمي

ADMINISTRATIVE FORM			
APP	DOCUMENT NAME	VERSION	DOCUMENT No.
	FLOWCYTOMETRY REQUST FORM	4	JRL.7.12.F9

Referring Hospital information			
Patient Name		MRN	
ID Number		Nationality	
Age/ Date of Birth		Gender	☐ Male ☐ Female
Referring Facility	King Abdul-Aziz Hospital-Jeddah	City / Address	
Ordering Physician		Physician's Phone #	
Physician's Signature		Stamp& Date	

Clinical Information

Clinical details:_____

_____

_____

☐ **Initial diagnosis**

For Leukemia/lymphoma/Myeloma immunophenotyping cases only

- ☐ Lymphadenopathy
- ☐ Mediastinal mass
- ☐ Splenomegaly
- ☐ Pathological Fracture

***Please submit copy of Reports:** CBC/Diff, retic, chemistry
***Please send blood and bone marrow (2) slides for all Leukemia/Lymphoma/Myeloma cases**

☐ **Follow up**

Currant Therapy:

- ☐ Chemotherapy
- ☐ Growth Factor
- ☐ Immunotherapy:_____
- ☐ Other:_____

Current Infection:

- ☐ HIV
- ☐ Other:_____

Specimen Information

Specimen Type	☐ Peripheral Blood ☐ Bone Marrow ☐ Other:_____

Specimen Collected by	Name	Signature	Stamp	Date	Time

Test Requested

- ☐ Leukemia/Lymphoma Immunophenotyping
- ☐ Myelodysplasia (if increased blasts)
- ☐ Multiple Myeloma/MGUS
- ☐ Myeloproliferative neoplasm (if increased blasts)
- ☐ Lymphocyte Subsets Enumeration (TBNK)
- ☐ Other:_____

For Regional Lab Use :			
Received by		Signature	
Time & Date of Receiving		Stamp	

N.B. : All information should be filled and completed to avoid Reception rejection for the patient's benefit.
N.B.: Please call the laboratory to confirm that the test can be performed before collection on :012 6375233 Ext:3391