Laboratoire d'Hématologie-Oncologie
Service de pédiatrie

Centre Hospitalier Universitaire Vaudois (CHUV) University Hospital of Lausanne Department of Pediatrics Pediatric Hematology-Oncology Research Laboratory

Sample Shipping Address: **Laboratoire d'Hémato-Oncologie Pédiatrique LHOP**
Institut de Pathologie, BU 25/03/104
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1011 Lausanne

Contact: Phone +41 21 31 43 622, Fax +41 21 31 43 664, Email:dmcp.laboratoire.hop@chuv.ch

Please ALWAYS enquire and/or inform us by email prior to shipping.

REQUESTING PHYSICIAN

FIRST NAME : _____
LAST NAME : _____

Institution/Address:

PATIENT IDENTIFICATION

FIRST NAME : _____
LAST NAME : _____

Address:

Date of Birth : ___/____/_____ **(DD/MM/YYYY)**
Gender : **Masc.** ☐ **Fem.** ☐

PATIENT CLINICAL INFORMATION

DIAGNOSIS:……..
CURRENT STATUS :

- ☐ Diagnostic sample
- ☐ On treatment/Planned follow-up, specify timepoint: …….....
- ☐ Relapse sample

SAMPLE INFORMATION

(tick all that apply)

Date of sample collection: ___/____/_____ **(DD/MM/YYYY)**

- ☐ Bone Marrow, specify site(s)/labeling……
- ☐ Peripheral Blood, specify ☐ EDTA, ☐ Heparin
- ☐ Tumor biopsy, specify site (Metastasis? Primary?):……..
  - ☐ TCC done, value: …… ☐ TCC not done
- ☐ Tumor cytoaspirate, specify site: ……..
- ☐ Slide/smear, specify tissue and staining/native:…….....
- ☐ PAX Tube, specify material/site: ☐ peripheral blood ☐ BM left ☐ BM right
- ☐ DNA/RNA, specify quantity and details: ……..
- ☐ Other: ……

REQUESTED TESTING

- ☐ SIOPEN Sample Review (Protocols SIOP-HR-NBL, LINES), Patient ID#:……
- ☐ GD-2 Neuroblastoma Immunocytochemistry
- ☐ Molecular studies (SNP array)
- ☐ FISH for MYCN
- ☐ FISH for other marker(s), please specify: ……
- ☐ Other: ……

COMMENTS: ……
PHYSICIAN SIGNATURE: …… **PHONE #:**……
PLACE: …… **DATE:** ……..