Seattle Children's
HOSPITAL · RESEARCH · FOUNDATION

Pediatric Blood and Marrow Transplant Program
Seattle Children's Hospital
Tel. 206.987.2106
Fax. 206.985.3437

FAX COVER SHEET

Date:

To: FAX:

From: RE:

Pages including cover:

Dear   ,

Per recommendation for the recommended bone marrow testing, the following sample(s) are needed for test completion:

- 2ml of bone marrow aspirate in NA Heparin for Cyto/FISH
- 1-2ml of bone marrow aspirate in NA Heparin for Immunophenotyping
- 1-2ml of bone marrow aspirate in NA Heparin for Chimerism
- For morphology:
  - ☐ If to be performed primarily at Seattle Children's Hospital: please send aspirate smear slides and core biopsy (latter in formalin)
  - ☐ If to be performed locally: after your pathology department has reviewed the case, please send bone marrow aspirate smears and core biopsy blocks and/or slides to SCH Pathology for review.

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SHIPMENT INSTRUCTIONS

1. **Complete the attached form** - Patient Registration and Facility Information.
2. **Label each tube** with:
   - Patient's name
   - Patient's date of birth
   - Date and time specimen collected
   - Type of specimen (i.e., peripheral blood, bone marrow, serum, breast mass, tissue etc)
3. **Ship the package** containing specimen(s), Test Request Form and Patient Registration/Facility Information Form) by overnight courier service (FedEx, DHL, etc) to:

   Seattle Children's Hospital
   Department of Laboratories
   4800 Sand Point Way NE FB.2.441
   Seattle, WA 98105

Please Note:
Do not send specimens to arrive on weekends or government holidays. (Do not draw samples on Fridays)
Send samples at room temperature unless otherwise instructed.
In response to Medicare 2011 changes to the Medicare Physician Fee Schedule, any laboratory test that is paid by the Clinical Lab Fee Schedule requires the ordering physician or qualified nonphysician practitioner to sign the lab requisition as well as the physician order.
Shipment charges are the responsibility of the patient or the facility sending the package. Fred Hutch will bill the patient or his/her insurance directly for testing. Please contact our office by phone at 206-987-2617 indicating when we should expect the package to arrive or if you have any further questions.