Document #00866 (rev. 03FEB10)

PhenoPath LABORATORIES
Expertise, Innovation and Excellence

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HEME/ONC REQUISITION FORM

THIS SECTION FOR PHENOPATH USE ONLY

HEME/ONC

CLINICAL SPECIMEN INFORMATION

Office/Inst where specimen collected: _____
Collection Date _____ Collection Time _____
Specimen ID: _____ Tissue Source(s): _____
☐ Peripheral Blood: ☐ green top ☐ purple top(s) ☐ other _____
☐ Bone Marrow: ☐ green top ☐ purple top(s) ☐ core biopsy ☐ clot ☐ other _____
☐ Fluid: ☐ CSF ☐ pleural ☐ other _____
☐ Fresh Tissue
☐ Smears: __ air dried __ fixed __ stained, type of stain: _____
☐ Other _____

☐ **CBC/WBC DIFFERENTIAL RESULTS REQUIRED - please attach**

NOTE: Flow Cytometry: Heparin preferred, EDTA ok
Fresh Specimens for PCR or FISH: EDTA preferred, Heparin ok

REQUEST

☐ Perform & interpret tests determined medically necessary by PhenoPath MDs
☐ Perform & interpret only test(s) as requested

CLINICAL HISTORY

☐ **Diagnosis / signs / symptoms (ICD-9 or description):** _____

Treatment status ☐ New dx ☐ Post-Tx ?remission ☐ Post-Tx ?relapse
Therapy ☐ Current ☐ Type: _____
☐ Prior (>1 mo. ago) ☐ Rituxan® ☐ Gleevec® ☐ Mylotarg® ☐ Campath® ☐ Velcade®
☐ Chemotherapy ☐ Radiotherapy ☐ EPO ☐ GCSF / GMCSF
☐ Other _____
Bone marrow transplant: Type: ☐ Autologous ☐ Allogeneic ☐ Sex mismatch

☐ **Lymphoproliferative disorders**
- ☐ CLL/SLL
- ☐ Follicular lymphoma (FL)
- ☐ Mantle cell lymphoma (MCL)
- ☐ Marginal zone lymphoma
- ☐ Hairy cell leukemia (HCL)
- ☐ Diffuse large B-cell lymphoma (DLBCL)
- ☐ Burkitt lymphoma
- ☐ Hodgkin lymphoma
- ☐ T-cell lymphoma/leukemia
- ☐ Other: _____

☐ **Plasma cell neoplasms / Multiple myeloma (MM)**
☐ **Myeloproliferative neoplasms**
☐ CML ☐ Polycythemia vera (PV) ☐ Essential thrombocytosis (ET)
☐ Primary myelofibrosis (PMF) ☐ Other _____
☐ **Myelodysplastic syndrome (MDS)** ☐ MDS ☐ CMML ☐ Other _____
☐ **Acute leukemia** ☐ AML ☐ APL ☐ ALL ☐ Other _____
☐ **Cytopenia** (specify): _____

COMPREHENSIVE BONE MARROW MORPHOLOGIC EVAL

☐ Bone Marrow Morphology

FLOW CYTOMETRY

☐ Lymphoma/mature LPD: Select one: ☐ B cell ☐ T cell ☐ Both B & T cell
☐ Acute lymphoblastic leukemia (ALL): Select one: ☐ B cell ☐ T cell
☐ Plasma cell dyscrasia ☐ CLL ☐ AML ☐ CML/MPD
☐ MRD testing for _____ ☐ PNH ☐ MDS
☐ ZAP-70/CD38 CLL Prognosis ☐ Other _____

CYTOGENETICS / FISH (may be sent to referral lab)

☐ Chromosome analysis w/karyotyping
☐ Karyotyping ☐ With reflexive FISH analysis (IF NEEDED)
FISH analysis: ☐ ALL ☐ AML ☐ APL ☐ CLL/SLL ☐ CML ☐ MDS ☐ MM
☐ Individual FISH probes _____

PCR

☐ B cell (IgH) # PCR0001 ☐ T cell (TCR-γ) # PCR0002 ☐ JAK2 # PCR0003

REQUESTING INSTITUTION NAME & ADDRESS

Phone _____ FAX _____

Ordering Pathologist/Physician

Name _____ NPI # _____

PATIENT INFORMATION

Name (Last, First, MI) _____
SSN # _____ DOB _____ ☐ Male ☐ Female
☐ Inpatient ☐ Outpatient ☐ Non-Hospital Patient
Address _____
_____ Phone _____
Medical Record # _____ Pt # _____

TREATING PHYSICIAN

_____
Name NPI #

☐ Mail/Fax add'l copy of report to treating physician
Complete information REQUIRED BELOW

Phone _____ Fax _____
Institution _____
Address _____
City, State Zip _____

BILLING INFO (Must be provided or Institution will be billed)
Please complete or attach copy of insurance card

BILL: ☐ Ins ☐ Medicare ☐ Medicaid (WA DSHS only) ☐ Institution ☐ Pt
Referral/Authorization # _____
Medicare # _____

REQUIRED
ICD-9 # _____

Advance Beneficiary Notice ☐ Yes (provide copy) ☐ No
Healthplan _____
Address _____
Policy/Cert # _____ Group/Plan # _____
Name of Insured _____ Relationship _____
Secondary Insurance ☐ Yes (Please attach separate sheet) ☐ No

REQUIRED

Person completing form _____
Date _____ Phone _____

Send: REQS: ☐ **DERM** ☐ **HEME** ☐ **HEMEONC** ☐ **MOL** ☐ **PATH** ☐ **HEMEONC Kits** ☐ **Flow Media (RPMI)**