

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 Diffuse large B-cell lymphoma (DLBCL)
 Follicular lymphoma (FL) Burkitt lymphoma
 Mantle cell lymphoma (MCL) Hodgkin lymphoma
 Marginal zone lymphoma T-cell lymphoma/leukemia
 Hairy cell leukemia (HCL) 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

Send: REQS: DERM HEME HEMEONC MOL PATH

HEME/ONC REQUISITION FORM
THIS SECTION FOR PHENOPATH USE ONLY
HEME/ONC

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 # _____ **REQUIRED**
Medicare # _____ 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 _____

HEMEONC Kits Flow Media (RPMI)