DIAGNOSTIC PATHOLOGY MEDICAL GROUP, INC.

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# HEMATOPATHOLOGY SPECIMEN REQUISITION FORM

(BONE MARROW, PERIPHERAL BLOOD, LYMPH NODES, OTHER)

**Pathology Accession**
*(For Laboratory Use Only)*

Form completed by: _____

Additional Copies of Report To (Name and Address): _____

_____

*Required Fields - Please fill out all information in box. Thank you.*

| Patient Name: Last, First | | | Date Biopsy Taken |
|---|---|---|---|
| Patient Address | City | Zip Code | Telephone Number |
| Date of Birth | Age | Sex | Social Security Number |

## SPECIMEN INFORMATION (Please indicate type of specimen, number of tubes / containers, and body site)

Collection Date: _____ Collection Time: _____ AM / PM ICD-9 Code(s): _____ / _____ / _____

☐ Blood: Green Top _____ Purple Top _____ Smears _____

☐ Bone Marrow: Green Top _____ Purple Top _____ Core Biopsy _____ Clot _____ Smears _____ Touch Preps _____

☐ Lymph Node: Body Site(s) _____

☐ Other Tissue: Body Site(s) _____

## CLINICAL DATA (Please provide copy of recent CBC and patient history notes)

Diagnosis under consideration / address what clinical question?

_____

Prior Therapy ☐ No ☐ Yes _____

CLINICAL HISTORY (Please attach recent summary of patient history or notes from recent clinical visit / hospitalization) _____

_____

## TESTS REQUESTED (*Indicates test is performed at Sutter Medical Center)

☐ **COMPREHENSIVE HEMATOPATHOLOGIC EVALUATION**
Comprehensive evaluation allows for complete hematopathologic assessment and inclusion of any additional testing deemed necessary to aid in prognostication and / or diagnosis of the disorder identified including (but not necessarily limited to) immunohistochemistry, flow cytometry, conventional cytogenetics, fluorescence in situ hybridization (FISH), and molecular analysis.

☐ **MORPHOLOGY** (and immunohistochemistry, if indicated)

☐ **FLOW CYTOMETRY** (Green Top / Sodium Heparin preferred; Purple Top / EDTA acceptable)

- ☐ Lymphoma Panel*
- ☐ Acute Leukemia Panel*
- ☐ Myeloma Panel*
- ☐ CLL Panel*
- ☐ PNH Evaluation
- ☐ Screening Panel (screens for lymphoproliferative disorders and blasts)*
- ☐ Perform panel as deemed appropriate by pathologist*
- ☐ ZAP-70

☐ **CONVENTIONAL CYTOGENETICS** (Green Top /Sodium Heparin required)

☐ Karyotype* ☐ Karyotype with reflex to FISH, if necessary ☐ Other _____

☐ **FLUORESCENCE IN SITU HYBRIDIZATION (FISH)** (Green Top /Sodium Heparin required)

- ☐ 11q23/MLL*
- ☐ t(11;14) (Mantle cell lymphoma)*
- ☐ t(14;18) (Follicular lymphoma, DLBCL)
- ☐ t(8;21)
- ☐ t(8;14) / IGH/MYC (Burkitt lymphoma)
- ☐ t(9;22) / BCR/ABL (CML)*
- ☐ IgH translocations*
- ☐ Other _____
- ☐ t(15;17) (APL)
- ☐ inv(16),t(16;16)
- ☐ MYC breakapart (Burkitt lymphoma)

☐ MDS Panel

| | |
|---|---|
| 5q31 | 20q12 |
| 7q31 | 8 centromere |

☐ CLL Panel*

| | |
|---|---|
| 11q22.3 | 17p13.1 |
| 13q14.3 | t(11;14) |
| 13q34 | 12 centromere |

☐ Myeloma Panel*

| | |
|---|---|
| 11q22.3 | 17p13.1 |
| 13q14.3 | 12 centromere |
| 13q34 | 14q32 brkprt probe |

☐ Pediatric ALL (COG) Panel*

| | |
|---|---|
| 11q23 | 10 centromere |
| t(9;22) | 17 centromere |
| t(12;21) | 4 centromere |

☐ **MOLECULAR ANALYSIS** (Purple Top / EDTA required)

- ☐ IgH and TCR
- ☐ IgH
- ☐ TCR
- ☐ JAK-2 mutation
- ☐ PML/RARA (APL)
- ☐ FLT3 mutation
- ☐ BCR-ABL (CML) – quantitative
- ☐ BCR-ABL (CML) – qualitative
- ☐ Other _____
- ☐ NPM1 (Exon 12) mutation

***For Bone Marrow Specimens – please enclose a copy of the patients CBC***

**INSURANCE** ☐ Copy of insurance card(s) attached ☐ Cash Pay

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