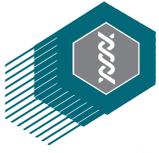


#4 ALL PTS



DIAGNOSTIC
PATHOLOGY
MEDICAL
GROUP, INC.

HEMATOPATHOLOGY SPECIMEN REQUISITION FORM

Pathology Accession
(For Laboratory Use Only)

3301 C Street, #200E, Sacramento, CA 95816
Customer Service and Courier Pickup
916-446-0424; Toll-free 800-464-0424
FAX 916-446-9330

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

Visit our Website: www.dpmginc.com 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-10 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* PNH Evaluation

Acute Leukemia Panel* Screening Panel (screens for lymphoproliferative disorders and blasts)*

Myeloma Panel* Perform panel as deemed appropriate by pathologist*

CLL Panel* 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)

<input type="checkbox"/> 11q23/MLL*	<input type="checkbox"/> t(15;17) (APL)	<input type="checkbox"/> MDS Panel	<input type="checkbox"/> Myeloma Panel*
<input type="checkbox"/> t(11;14) (Mantle cell lymphoma)*	<input type="checkbox"/> inv(16),t(16;16)	5q31 20q12	11q22.3 17p13.1
<input type="checkbox"/> t(14;18) (Follicular lymphoma, DLBCL)	<input type="checkbox"/> MYC breakapart (Burkitt lymphoma)	7q31 8 centromere	13q14.3 12 centromere
<input type="checkbox"/> t(8;21)			13q34 14q32 brkprt probe
<input type="checkbox"/> t(8;14) / IGH/MYC (Burkitt lymphoma)		<input type="checkbox"/> CLL Panel*	<input type="checkbox"/> Pediatric ALL (COG) Panel*
<input type="checkbox"/> t(9;22) / BCR/ABL (CML)*		11q22.3 17p13.1	11q23 10 centromere
<input type="checkbox"/> IgH translocations*		13q14.3 t(11;14)	t(9;22) 17 centromere
<input type="checkbox"/> Other _____		13q34 12 centromere	t(12;21) 4 centromere

MOLECULAR ANALYSIS (Purple Top / EDTA required)

<input type="checkbox"/> IgH and TCR	<input type="checkbox"/> JAK-2 mutation	<input type="checkbox"/> BCR-ABL (CML) – quantitative	<input type="checkbox"/> NPM1 (Exon 12) mutation
<input type="checkbox"/> IgH	<input type="checkbox"/> PML/RARA (APL)	<input type="checkbox"/> BCR-ABL (CML) – qualitative	
<input type="checkbox"/> TCR	<input type="checkbox"/> FLT3 mutation	<input type="checkbox"/> Other _____	

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

INSURANCE	<input type="checkbox"/> Copy of insurance card(s) attached	<input type="checkbox"/> Cash Pay
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