

**PATHOLOGY REFERENCE LABORATORY, L.L.C.**



**HEMATOLOGY REQUISITION**

9600 DATAPOINT DR. • SAN ANTONIO, TX 78229  
 TELE (210) 892-3700 • TOLL FREE (866) 231-8058 • FAX (210) 617-4692

COLLECTION DATE: \_\_\_\_\_

\_\_\_\_/\_\_\_\_/\_\_\_\_

BILL TO:

- CLIENT  
 PATIENT  
 OTHER

**ACCOUNT NAME AND ADDRESS**

PATIENT LAST NAME		FIRST		M.I.	
RELATIONSHIP TO INSURED: <input type="radio"/> SELF <input type="radio"/> SPOUSE <input type="radio"/> DEPENDENT					
PHONE ( )	PATIENT SS #	PATIENT ID/MR #	DATE OF BIRTH / /	SEX <input type="radio"/> F <input type="radio"/> M	
INSURED NAME/RESPONSIBLE PARTY			INSURED SS #		
PATIENT ADDRESS (OR INSURED RESPONSIBLE PARTY)					APT. NO.
CITY			STATE	ZIP	
EMPLOYEE NAME			PHONE ( )		
INSURANCE COMPANY NAME					
INSURANCE COMPANY ADDRESS					
CITY			STATE	ZIP	
INSURANCE COMPANY PHONE ( )		INSURANCE/GROUP #		MEMBER/SUBSCRIBER ID #	
MEDICARE #		SUFFIX <input type="radio"/> PRIMARY <input type="radio"/> SECONDARY	MEDICAID #		STATE

Send duplicate report to:

Name \_\_\_\_\_ Address/Fax \_\_\_\_\_

**ICD-9 CODE (Required)**

**SPECIMEN INFORMATION (A separate report will be generated for each body site submitted)**

COLLECTION DATE \_\_\_\_\_ TIME \_\_\_\_\_  AM  PM  
 SPECIMEN ID # \_\_\_\_\_ BODY SITE \_\_\_\_\_  
 PRIMARY SPECIMEN TO BE TESTED  BONE MARROW  BLOOD  NODE  OTHER  
 BLOOD TUBE(S) # PURPLE \_\_\_\_\_ (ASPIRATE) # PURPLE \_\_\_\_\_ (EXTRA)  
 BM ASPIRATE TUBE(S) # GREEN \_\_\_\_\_ (FLOW) # GREEN \_\_\_\_\_ (CYTOGENETICS)  
 SMEARS/TOUCH PREPS # BLOOD \_\_\_\_\_ # BM ASP \_\_\_\_\_ # BM BIOPSY \_\_\_\_\_ # TISSUE \_\_\_\_\_  
 BM CLOT  BM BIOPSY  FRESH TISSUE  FLUID  
 PARAFFIN BLOCK(S) \_\_\_\_\_ FIXATIVE \_\_\_\_\_  
 SLIDES # STAINED \_\_\_\_\_ # UNSTAINED \_\_\_\_\_

**CLINICAL INFORMATION**

**CBC RESULTS** (Must attach most recent CBC or complete below)  
 WBC \_\_\_\_\_ HGB \_\_\_\_\_ HCT \_\_\_\_\_ MCV \_\_\_\_\_  
 RDW \_\_\_\_\_ PLT CT \_\_\_\_\_ RETIC \_\_\_\_\_  
 DIFFERENTIAL \_\_\_\_\_  
**INDICATIONS**  ANEMIA  CYTOPENIA  LEUKO  THROMBO  
 CYTOSIS  LEUKO  THROMBO  ERYTHRO  
 MONOCLONAL GAMMOPATHY  IGM  IGG  IGA  
 KAPPA  LAMBDA  
 LYMPHADENOPATHY  SPLENOMEGALY  
 LYMPHOMA/CA STAGING  FUO  
**PATIENT HISTORY / COMMENTS** \_\_\_\_\_

**TEST REQUEST**

- MORPHOLOGIC EVALUATION  
 FLOW CYTOMETRY / IMMUNOPHENOTYPING  
 CYTOGENETICS  
 PATHOLOGIST WILL DETERMINE NEED FOR FLO/CYTOGENETICS  
 DIAGNOSTIC CONSULTATION (ON PREPARED BLOCKS AND SLIDES)

**HEMATOPATHOLOGY PROFILES**

- MORPHOLOGIC EVALUATION
- P1 ACUTE LEUKEMIA OR MDS ASSESSMENT: FLOW CYTOMETRY IMMUNOPHENOTYPING CYTOGENETICS
- P2 ACUTE PROMYELOCYTIC LEUKEMIA ASSESSMENT: FLOW CYTOMETRY IMMUNOPHENOTYPING CYTOGENETICS (15:17) ANALYSIS BY FISH CYTOGENETICS
- P3 ACUTE PROMYELOCYTIC LEUKEMIA FOLLOW-UP: CYTOGENETICS (15:17) ANALYSIS BY RT-PCR\*
- P4 CML ASSESSMENT: FLOW CYTOMETRY IMMUNOPHENOTYPING CYTOGENETICS (9:22) ANALYSIS BY FISH CYTOGENETICS

\*RT-PCR testing performed only when (15:17) is not identified by FISH or cytogenetics.

COMMENTS / REQUESTS

**DIAGNOSIS**  UNDER CONSIDERATION  CONFIRMED

- ACUTE LEUKEMIA  
 NOS  AML  ALL  
 MYELODYSPLASTIC SYNDROME (MDS)  
 MYELOPROLIFERATIVE DISORDER  
 CML  CAMMol  MYELOFIBROSIS  PVERA  ET  
 NON-HODGKINS LYMPHOMA  
 B-CELL  T-CELL  KI-1  FOLLICULAR  MANTLE CELL  
 HODGKINS DISEASE  
 SOLID TUMORTYPE \_\_\_\_\_  
 PRIMARY  METASTATIC  
 CHRONIC LYMPHOPROLIFERATIVE DISORDER  
 CLL  HCL  
 MULTIPLE MYELOMA  
 IMMUNE DISORDER  
 IMMUNODEFICIENCY  HIV/AIDS  
 NOS/OTHER \_\_\_\_\_  
**STATUS**  NEW OX  POST TX \_\_\_\_\_ DAYS  RELAPSE  
**THERAPY**  BONE MARROW TRANSPLANT  
 SPECIFY \_\_\_\_\_  
 CYTOKINE THERAPY-SPECIFY \_\_\_\_\_