Flow Cytometry Requisition

ACCOUNT INFORMATION

Account name: _____

Address: _____ **City:** _____ **State:** _____

Zip code: _____ **Ph:** _____ **Fax:** _____

Flow Cytometry Laboratory
2330 Inwood Road, Suite EB3.304
Dallas, Texas 75235
LAB PHONE: 214-648-0930
LAB FAX: 214-648-0940
CUSTOMER SERVICE: 214-633-5227
CLIA #: 45D-0861764
CAP #: 2664213

UT Southwestern Medical Center
CLINICAL LABORATORY SERVICES

REQUIRED ORDER INFORMATION

BILL TO: ☐ Facility / Client ☐ Patient / 3rd party **– Billing information must be provided**

Patient Name: (Last, First, Middle)

Mother's Name: (if infant)

Date of Birth: | Sex: | Patient ID / MR#:

Hospital Inpatient Y / N | Collection Date: | Collection Time: AM : PM

Ordering Physician (Full Name): | NPI:

Phone: | Pager: | FAX:

Clinical Indication for Tests Ordered:

PATIENT/3RD PARTY BILLING INFORMATION

ICD-10 Code(s)

Medicare patients with non-covered diagnoses must sign Advanced Beneficiary Notice (ABN) available at www.veripathlabs.com or by calling customer service at 214-645-7057 or toll free 877-887-8136 ☐ Signed ABN included

ICD-10 Codes applicable to each and every test requested should come only from the ordering physician, represent the reason for the test order at the time of order, and be supported by the patient's medical record. Physicians should order only tests that are medically necessary for the diagnosis or treatment of the patient. Tests ordered should be single laboratory tests appropriate for the patient's medical condition. Tests for screening purposes may be ordered, but may not be reimbursed.

Insured/Responsible Party Name: (if different from patient-Last, First, Middle) | Date of Birth:

Patient's relationship: ☐ Self ☐ Spouse ☐ Dependent ☐ Other

Responsible Party Address: (street, city, State, zip)

Sex: | Phone:

Employer's Name: | Employer's Phone:

Insurance Co. Name: | Insurance Co. Phone:

Insurance Co. Address:

Policy #: | Group #:

☐ Medicare ☐ HMO ☐ Other ☐ Medicaid ☐ PPO | Member ID#:

Referral Authorization/Precertification #:

Name: | Date/Time:

SPECIMEN INFORMATION

☐ Bone Marrow
☐ Peripheral Blood
☐ CSF
☐ Body Fluid (source): _____
☐ Biopsy (source): _____
☐ Tissue (source): _____
☐ FNA (source): _____
☐ Other: _____

NOTE: Submit one specimen per container CLEARLY LABELED.
Submit smear and CBC copy when requesting analysis of marrow or blood.

CLINICAL INFORMATION

Primary Physician: (if different from above)

Phone: | Pager: | FAX:

FOR IMMUNOPHENOTYPING CASES ONLY

☐ Lymphadenopathy ☐ Mediastinal Mass ☐ Splenomegaly

FOR ALL CASES

Current Therapy

☐ Chemotherapy
☐ Growth Factor
☐ Immunotherapy: _____
☐ Other: _____

☐ Down Syndrome

Current Infection

☐ HIV
☐ Other: _____

TEST REQUESTED

IMMUNOPHENOTYPING:

☐ Leukemia/Lymphoma Immunophenotyping

☐ Leukemia/Lymphoma Immunophenotyping MRD
Select Type: ☐ CLL (0.001%) ☐ AML (0.01%) ☐ BLL (0.01%) ☐ TLL (0.01%)

☐ PNH Panel (Paroxysmal Nocturnal Hemoglobinuria)

☐ Leukemia/Lymphoma Immunophenotyping CART-19 (Immunotherapy)
Specify therapy: _____

☐ BAL (Bronchoalveolar Lavage) CD4:CD8

☐ Leukemia/Lymphoma CSF (Cerebrospinal Fluid)

☐ Leukemia/Lymphoma FLUID (Other Fluid, not CSF)

☐ Process and hold sample for Immunophenotypic analysis (Client should call next day with instructions)

☐ Other Markers: _____

IMMUNODEFICIENCY WORKUP:

Must Provide:

WBC count _____ $10^3/\mu L$ Lymphs _____ % Atypical Lymphs _____ %

☐ T & B Cell subset quantification, including NK's (CD3, CD4, CD8, CD19, CD16+56)
☐ CD4 quantification (HIV monitoring)
☐ CD3 quantification (Transplant monitoring)
☐ T-Cell subset quantification (CD3, CD4, CD8)
☐ CD3 B-cell (CART)
☐ Extended Lymph Subset Panel
☐ Severe Combined Immunodeficiency (SCID)
☐ B-Cell Total Count (CD19)
☐ B & NK Cell Subset Panel (CD19 & CD16+56)
☐ NK Cell Total Count (CD16+56)

LAB USE ONLY

Transport Container: ___Yellow ___Green ___Purple ___Syringe ___Conical ___Red ___Blue ___Cup ___Trans Tube ___Block ___Slides ___Formalin ___Other: _____

Total # of specimens: _____

Transport Conditions: ☐ Frozen ☐ Slushy ☐ Refrig ☐ Room Temp

Destination: ☐ Other _____ ☐ Coag ☐ Cytogen ☐ Hemepath ☐ Flow ☐ Hist ☐ Mol Dx

Initials: