# Hematopathology Requisition

DRL Diagnostic Reference Laboratories
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UF UNIVERSITY of FLORIDA

**Complete For All Patients**

| Patient Name (Last) (First) (M.I.) | | | | Patient ID # | Date of Birth / / | Sex M F |
|---|---|---|---|---|---|---|
| Street Address | City | State | Zip | Patient Phone | | |
| Ordering Physician | Duplicate Report Sent To: | Bill To: ☐ Client ☐ Patient ☐ Insurance ☐ Mcare/Mcaid | | | | |

**Complete To Bill Third Party**

| Primary Insurance Name | Address | City | State | Zip |
|---|---|---|---|---|
| ID/Member # | Group # | Subscriber Name | DOB | |
| Secondary Insured Name | Address | City | State | Zip |
| ID/Member # | Group # | Subscriber Name | DOB | |
| Patient relationship to insured: ☐ Self ☐ Spouse ☐ Dependent | | Collection Date/Time: | | |

**Physicians:** ☐ ☐ ☐

## CLINICAL HISTORY/ QUESTION:

| ICD-9 | ICD-9 | ICD-9 | ICD-9 |
|---|---|---|---|

## CLINICAL/LABORATORY INFORMATION (CHECK ALL THAT APPLY)

☐ Anemia ☐ Leukopenia ☐ Thrombocytopenia
☐ Leukocytosis ☐ Lymphocytosis ☐ Abnormal Cells on Smear
☐ Lymphadenopathy ☐ Mass ☐ Skin Lesion
☐ Serosal Effusion ☐ Splenomegaly ☐ Hepatomegaly
☐ Bone Lesions ☐ Ser/Urine Abnormal Immunoglobulin
☐ Other:______________________

## CLINICAL HISTORY (CHECK ALL THAT APPLY)

☐ Lymphoma (type):____________________________________________
☐ MDS/MPD (type):____________________________________________
☐ Leukemia (type):____________________________________________
☐ Solid tumor (type):__________________________________________
☐ Myeloma ☐ Other:______________________
☐ Post-therapy (days):_______ ☐ Post-transplant (days):_______
☐ EPO/Epogen/Procrit treatment ☐ G-CSF/Neupogen/Filgrastim treatment

## SPECIMEN INFORMATION

Date Collected:______________Time Collected:______________

☐ Peripheral Blood ☐ Bone Marrow Core Bx
☐ Tissue-Fresh ☐ Bone Marrow Aspiration
☐ Body Fluid ☐ Tissue-Fixed
☐ Tissue Site:_______ ☐ Other:______________________

## FLOW CYTOMETRY STUDIES / MOLECULAR STUDIES

Note: ☐ ***Check this box if you want a hematopathologist to order all medically indicated flow cytometry and/or molecular tests.***

**Flow Cytometry Studies**

☐ Flow for Bone Marrow w/o Biopsy
☐ Flow for Bone Marrow with Biopsy
☐ Flow for Peripheral Blood
☐ Flow for tissue/body fluid
☐ Flow DNA (ploidy, S-phase)
☐ PNH
☐ Reflex CD38/ZAP-70 (CLL)

**Molecular Studies**

☐ B cell clonality
☐ T cell clonality
☐ BCL2 translocation
☐ JAK 2 V617f mutation

## CYTOGENETIC/ FISH ANALYSIS REQUEST

**Cytogenetic Testing Requested** /***Conventional Chromosome Analyses (Karyotyping)*** *(must be completed to avoid delays in processing)*

☐ ***Check this box if you want a hematopathologist to order all medically indicated cytogenetic and/or FISH to establish a diagnosis and determine prognosis.***

☐ Bone marrow chromosome study ☐ Peripheral blood chromosome study ☐ Solid tumor chromosome study ☐ Lymphatic tissue study
☐ Other chromosome study______________________

***FISH Analyses*** *(If probe not specified, please contact the laboratory.) (select entire panel or customize your own panel)*

***ALL***
☐ **Panel (all listed)**
- ☐ t(9;22) BCR/ABL1
- ☐ 11q23 (MLL)
- ☐ t(12;21) ETV6/RUNX1
- ☐ 4/10/17 aneuploidy

***AML***
☐ **Panel (all listed)**
- ☐ t(15;17)
- ☐ Inv 16 CBFB
- ☐ t(8;21) ETO/AML1
- ☐ 8 cen
- ☐ MLL

***CLL***
☐ **Panel (all listed)**
- ☐ del 13q
- ☐ trisomy 12
- ☐ del 11q22 ATM
- ☐ del 17 (p53)

***MDS /MPD***
*(after negative cytogenetics)*
☐ **Panel (all listed)**
- ☐ 5q
- ☐ 7q31
- ☐ 8 cen
- ☐ 20q12

***Lymphomas***
*(select from list)*
- ☐ C-MYC
- ☐ IGH/BCL2
- ☐ t(11;14)Cyclin D1
- ☐ BCL6
- ☐ ALK

***Multiple Myeloma***
☐ **Panel (all listed)**
- ☐ del(13q)
- ☐ p53
- ☐ IGH break-apart (14q32)
  *if IGH positive & if necessary:*
  - ☐ IGH/CCND1 [t(11;14)]
  - ☐ IGH/FGFR3 [t(4;14)]
  - ☐ IGH/MAF [t(14;16)]

☐ Other *(please inquire as to availability):* ____________________

**For Lab Use Only** *Lab No.:*__________________ *Test Codes:* __________________ *Specimen Description:* __________________________

***352.265.9900 Phone*** ***888.375.5227 Toll Free*** ***352.265.9901 Fax***

**PERMISSION FOR TREATMENT AND AUTHORIZATION FOR ASSIGNMENT OF BENEFITS:**

Authorization is given to University of Florida Diagnostic Reference Laboratories to release any information including examination, diagnosis and treatment, to my insurance carrier.

I request my insurance carrier to pay University of Florida Diagnostic Reference Laboratories benefits due me related to my pending claim for medical and surgical services.

My signature is on the front side of this form.