

Highlighted fields are required information

PATIENT INFORMATION		
Last Name	First Name	MI
Street Address		Apt#
City	State	Zip
Phone	DOB	Sex
Patient MR#		

CLIENT INFORMATION

BILLING INFORMATION
<b>Attach a copy of the patient's demographic sheet, both sides of the patient's insurance card(s) and all secondary insurance information (if applicable).</b>
<b>Attach the Following:</b> <input type="checkbox"/> Copy of Recent CBC <input type="checkbox"/> Copy of Doctor's Notes/Clinical History
<b>ICD Code(s)</b> Please provide applicable "symptomatic diagnosis" codes _____
<b>Patient Status:</b> <input type="radio"/> Non-Hospital <input type="radio"/> Hospital In-Patient <input type="radio"/> Hospital Out-Patient

PERTINENT INDICATION OR CLINICAL HISTORY <small>Check all that apply</small>	
<b>Type of Study:</b> <input type="checkbox"/> Initial/Diagnostic <input type="checkbox"/> Follow-up/Monitoring <input type="checkbox"/> Staging Marrow <input type="checkbox"/> Anemia <input type="checkbox"/> Leukopenia <input type="checkbox"/> Thrombocytopenia <input type="checkbox"/> Pancytopenia <input type="checkbox"/> Leukocytosis <input type="checkbox"/> Erythrocytosis <input type="checkbox"/> Thrombocytosis <input type="checkbox"/> Neutrophilia <input type="checkbox"/> Eosinophilia <input type="checkbox"/> Monocytosis <input type="checkbox"/> Blasts in Blood <input type="checkbox"/> Lymphocytosis <input type="checkbox"/> Monoclonal Gammopathy <input type="checkbox"/> Other: _____	<input type="checkbox"/> History of <input type="checkbox"/> Rule out <input type="checkbox"/> AML <input type="checkbox"/> MDS <input type="checkbox"/> MPN <input type="checkbox"/> CML <input type="checkbox"/> B-ALL <input type="checkbox"/> T-ALL <input type="checkbox"/> CLL/SLL <input type="checkbox"/> B-NHL (type) _____ <input type="checkbox"/> T-NHL (type) _____ <input type="checkbox"/> Hodgkin Lymphoma <input type="checkbox"/> Hepatosplenomegaly <input type="checkbox"/> Bone Lesions <input type="checkbox"/> Skin Lesions <input type="checkbox"/> Carcinoma (type) _____ <input type="checkbox"/> Other _____
<b>PRIOR THERAPY OR OTHER RELEVANT CLINICAL INFORMATION <small>Check all that apply</small></b> <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Radiation <input type="checkbox"/> Rituxan <input type="checkbox"/> Other _____ <input type="checkbox"/> Growth Factor <input type="checkbox"/> Campath <input type="checkbox"/> Tyrosine Kinase Inhibitor	
<b>OTHER APPLICABLE HISTORY/REASON FOR BIOPSY</b> _____	

SPECIMEN INFORMATION <small>Indicate number of tubes, vials, slides or tissue blocks provided</small>
Date of Collection: _____ / _____ / _____ AM _____ PM
<b>Bone Marrow Biopsy:</b> Core # _____ Clot # _____ Touch Preparations # _____
<b>Bone Marrow Aspirate:</b> Green-top(s) (Na Heparin) # _____ Purple-top(s) (EDTA) # _____ Smears # _____ <b>Practice Lab:</b> Green-top(s) _____ Purple-top(s) _____
<b>Peripheral Blood:</b> Green-top(s) (Na Heparin) # _____ Purple-top(s) (EDTA) # _____ Smears # _____ <b>Practice Lab:</b> Green-top(s) _____ Purple-top(s) _____
<b>Tissue Biopsy:</b> Tissue Type/Location _____ <input type="checkbox"/> Paraffin Block <input type="checkbox"/> Formalin Fixed <input type="checkbox"/> Fresh in RPMI <input type="checkbox"/> Fresh in Saline Specimen ID# _____
<b>Other (CSF, FNA, Body Fluid, etc. — include location):</b> _____

COMPREHENSIVE TESTING
<input type="checkbox"/> <b>Comprehensive Bone Marrow or Peripheral Blood Diagnostic Analysis*</b> Hematopathologist will determine medically appropriate testing based on clinical data and morphologic findings. Select level of service for flow cytometry testing in Lab Partnership Program section below.

LAB PARTNERSHIP PROGRAM
<b>Flow Cytometry: Leukemia/Lymphoma Panel</b> <input type="checkbox"/> My Lab Performs Flow Cytometry <input type="checkbox"/> Inform Diagnostics Performs Flow Cytometry

INDIVIDUAL DIAGNOSTIC/PROGNOSTIC TESTS <small>Select individual tests below</small>		
<b>Morphology/Microscopic Evaluation</b> <i>Selected stains will be performed as medically necessary</i> <input type="checkbox"/> Morphology Evaluation <input type="checkbox"/> Consult <b>Flow Cytometric Analysis</b> <input type="checkbox"/> Leukemia/Lymphoma Panel <input type="checkbox"/> ZAP-70 for CLL – Blood Only <input type="checkbox"/> PNH Evaluation – Blood Only <b>Cytogenetic Analysis*</b> <input type="checkbox"/> Cytogenetic Analysis Only <input type="checkbox"/> Cytogenetic Analysis with reflex to FISH if clinically indicated <b>Fluorescence In Situ Hybridization (FISH)*</b> <input type="checkbox"/> AML <input type="checkbox"/> MDS <input type="checkbox"/> CML (BCR/ABL) <input type="checkbox"/> Eosinophilia <input type="checkbox"/> B-ALL <input type="checkbox"/> T-ALL <input type="checkbox"/> CLL <input type="checkbox"/> B-cell NHL <input type="checkbox"/> MM <input type="checkbox"/> Individual Probes (see reverse)	<b>Molecular Testing (with Interpretation)</b> CML or B-ALL <input type="checkbox"/> Quantitative BCR/ABL (by PCR) <input type="checkbox"/> ABL Kinase Domain Mutation (Including T315I) (for patients with known and treated disease only) Myeloproliferative Neoplasms <input type="checkbox"/> MPN Panel (JAK2 V617F reflex to JAK2 Exon 12, CALR and/or MPL W515K/L as medically appropriate.) AML <input type="checkbox"/> AML Prognostic Panel (Known AML Diagnosis Only) (FLT3 and NPM1 with reflex to CEBPA) <input type="checkbox"/> Perform IDH1/IDH2 as part of AML Panel APL Monitoring <input type="checkbox"/> Quantitative PML/RARA (48-hour stability)	Mastocytosis <input type="checkbox"/> KIT (D816V) Mutation Lymphoproliferative Disorder <input type="checkbox"/> B-Cell Clonality/Gene Rearrangement <input type="checkbox"/> T-Cell Clonality/Gene Rearrangement <input type="checkbox"/> IGHV Mutation Analysis (CLL) <input type="checkbox"/> BCL-1 (Mantle Cell Lymphoma) <input type="checkbox"/> MYD88 L265P (Waldenstrom/Lymphoplasmacytic) Other _____
<small>*Peripheral blood is not an optimal specimen for Cytogenetics or FISH except for CLL and CML.</small>		

**Contact 855.856.0656 or HemeClientServices@InformDx.com to arrange specimen pickup.**  
**See reverse for optimal specimen requirements and FISH probes.**

4207 E. Cotton Center Blvd. / Phoenix, AZ 85040 / 855.856.0656 / Fax: 855.856.0655 / CLIA 03D1064744 / MLS-20-0529.3 3/18  
 Inform Diagnostics (White) Client Copy (Yellow) Practice Lab Copy (Pink)

1. Complete all requested information on requisition.
2. Use appropriate number of labels provided.
3. Place one label on each specimen and dispose of the remaining labels.

A1 Pt. Name _____ DOB ____/____/____ PB A	HE-0000001	B2 Pt. Name _____ DOB ____/____/____ PB A	HE-0000001	C3 Pt. Name _____ DOB ____/____/____ PB A	HE-0000001	D4 Pt. Name _____ DOB ____/____/____ PB A	HE-0000001	E5 Pt. Name _____ DOB ____/____/____ PB A	HE-0000001
F6 Pt. Name _____ DOB ____/____/____ PB A	HE-0000001	G7 Pt. Name _____ DOB ____/____/____ PB A	HE-0000001	H8 Pt. Name _____ DOB ____/____/____ PB A	HE-0000001	I9 Pt. Name _____ DOB ____/____/____ PB A	HE-0000001	J10 Pt. Name _____ DOB ____/____/____ PB A	HE-0000001

**Please discard extra labels**

**Hematology/Oncology Optimal Specimen Requirements**

The matrix below indicates the optimal specimens required for testing. Please include as many specimens as possible for each technology. For a complete and timely analysis, please include all recommended specimen types.

TEST/TECHNOLOGY	BONE MARROW CORE	BONE MARROW CLOT	BONE MARROW ASPIRATE	PERIPHERAL BLOOD	PERIPHERAL BLOOD SMEAR	LYMPH NODES/ FRESH TISSUE	FIXED TISSUE (PARAFFIN BLOCK W/H&E)	FLUIDS	STORAGE & TRANSPORT
<b>Comprehensive Bone Marrow Analysis</b>	Place in 10% formalin	Place in 10% formalin	2-3 ml in green-top (sodium heparin) tube <b>AND</b> 0.5-1.0 ml in purple-top (EDTA) tube	2-3 ml in purple-top (EDTA) tube and CBC (a CBC will be performed if not submitted)	2 freshly prepared smears preferred				Store at room temperature. Use <b>FROZEN</b> cold pack for transport.
<b>Comprehensive Bone Marrow Analysis (Dry Tap)</b>	One (1) core in formalin and one (1) core in RPMI <sup>†</sup>			2-3 ml in green-top (sodium heparin) tube <b>AND</b> 2-3 ml in purple-top (EDTA) tube	2 freshly prepared smears preferred				Store at room temperature. Use <b>FROZEN</b> cold pack for transport.
<b>Comprehensive Peripheral Blood Analysis</b>				2-3 ml in green-top (sodium heparin) tube <b>AND</b> 2-3 ml in purple-top (EDTA) tube	2 freshly prepared smears preferred				Store at room temperature. Use <b>FROZEN</b> cold pack for transport.
<b>Morphology</b>	At least four (4) touch preparations (air-dried). Place core in 10% formalin	Place in 10% formalin	4-5 freshly prepared smears preferred <b>and</b> 1 ml aspirate in purple-top (EDTA)	2-3 ml in purple-top (EDTA) tube and CBC (a CBC will be performed if not submitted)	2 freshly prepared smears	Place in 10% formalin	Representative paraffin block		Store at room temperature. Use <b>FROZEN</b> cold pack for transport.
<b>Flow Cytometry</b>			2-3 ml in purple-top (EDTA) tube preferred	2-3 ml in purple-top (EDTA) tube preferred		Representative tissue in RPMI <sup>†</sup>		Representative fluid	Store at room temperature. Use <b>FROZEN</b> cold pack for transport.
<b>ZAP-70 for CLL or PNH Evaluation</b>				2-3 ml in purple-top (EDTA) tube preferred					Store at room temperature. Use <b>FROZEN</b> cold pack for transport.
<b>Immunohistochemistry (IHC)</b>	Place in 10% formalin	Representative paraffin block				Place in 10% formalin	Representative paraffin block		Store at room temperature. Use <b>FROZEN</b> cold pack for transport.
<b>Cytogenetics - Karyotype</b>			2-3 ml in green-top (sodium heparin) tube	2-3 ml in green-top (sodium heparin) tube <i>Peripheral blood is not an optimal specimen for Cytogenetics except for CLL and CML</i>					Store at room temperature. Use <b>FROZEN</b> cold pack for transport.
<b>Fluorescence in situ Hybridization (FISH)</b>			3 ml in green-top (sodium heparin) preferred or purple-top (EDTA) tube	3 ml in green-top (sodium heparin) preferred or purple-top (EDTA) tube* <i>Peripheral blood is not an optimal specimen for FISH except for CLL and CML</i>					Store at room temperature. Use <b>FROZEN</b> cold pack for transport.
<b>Molecular (PCR, Sequencing)</b>			2-3 ml in purple-top (EDTA) tube	2-3 ml in purple-top (EDTA) tube			Representative paraffin block		Store at room temperature. Use <b>FROZEN</b> cold pack for transport.

† **DO NOT** use RPMI if it is cloudy, yellow or is at or beyond expiration date. Use only pink/orange RPMI. If RPMI is not available, use saline.

**FISH:** The panels are designed to detect the most common abnormalities for a given disease group. Additional probes may be added to further characterize abnormalities found in the primary panel(s). Peripheral blood is not an optimal specimen for Cytogenetics or FISH except for CLL and CML.

<b>B-ALL</b> PBX1/TCF3[t(1;19)] CEP 4 p16 (9p21)/CEP9 CEP 10 BCR/ABL t(9;22) MLL (11q23) TEL/AML1 t(12;21)	<b>T-ALL</b> 9p21/CEP 9 BCR/ABL t(9;22)] MLL (11q23) p53 (17p13.1)	<b>AML</b> RPN1/MECOM inv(3)/t(3;3) ETO (RUNX1T1)/ AML1 (RUNX1) t(8;21) MLL (11q23) PML/RARA t(15;17) CBFβ inv(16)/t(16;16)	<b>CLL</b> MYB (6q23.3) ATM (11q22.3) CCND1/IgH t(11;14) CEP 12 D13S319 (13q14.3) p53 (17p13.1)	<b>CML</b> BCR/ABL t(9;22)	<b>Eosinophilia</b> PDGFRA/FIP1L1 (4q12) PDGFRB (5q32-q33) FGFR1 (8p12)
<b>MDS</b> RPN1/MECOM inv(3)/t(3;3) EGR1 (5q31) D7S522 (7q31) CEP 8 MLL (11q23) RB1 (13q14.2) D20S108 (20q12)	<b>MM</b> CKS1B/CDKN2C (1q21/1p32.3) FGFR3/IgH t(4;14) CEP 7 CEP 9 CCND1/IgH t(11;14) RB1 (13q14.2) IgH/MAF (14;16) p53 (17p13.1)	<b>B-cell NHL</b> BCL6 (3q27) c-MYC (8q24) CCND1/IgH t(11;14) IgH/BCL2 t(14;18) MALT1 (18q21)  <i>Bone marrow aspirate and FFPE are acceptable specimen types.</i>	<b>Anaplastic Large Cell Lymphoma</b> ALK (2p23)  <b>Follicular Lymphoma</b> IgH/BCL2 t(14;18)	<b>Burkitt Lymphoma</b> c-MYC (8q24)  <b>Mantle Cell Lymphoma</b> CCND1/IgH t(11;14)	<b>Additional Available Probes</b> (Undecalcified Formalin-Fixed Tissues Only) Her2/CEP17 ROS1 Melanoma (CCND1, RREB1, MYB/CEP6, RREB1/CEP6, CDKN2A/CEP9) Glioblastoma (1pq/19pq)

\*Inform Diagnostics medical staff will select the number and type of antibodies, other reagents or probes that are necessary. In keeping with the requirements of Medicaid and Medicare, it is the policy of Inform Diagnostics to only perform testing that is medically necessary for the diagnosis and treatment of the patient. Medicare does NOT pay for routine screening tests.

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