HEMATOPATHOLOGY TESTING SERVICES REQUISITION

The space above this line is for laboratory use only.

20 Northpointe Parkway - Suite 100
Amherst, NY 14228
(716) 250-9235 Fax (716) 250-9242

Date & Time Collected

Date & Time Received (Lab Use)

Ordering Physician / Client

Signature of Requesting Physician (Required)

PLEASE PRINT ALL INFORMATION CLEARLY

Patient Name	Last	First
Address		
City State Zip		

D.O.B.		Sex		Phone	

☐ Outpatient ☐ Inpatient - Room # Medical Record #

MEDICARE	☐ Primary	☐ Secondary	☐ Regular (Part B)	☐ Railroad
	#			
MEDICAID	#			

ICD-10 Code (Mandatory)	ICD-10 Code	ICD-10 Code	ICD-10 Code

COPY OF REPORT TO: **(FAX NUMBER MUST BE PROVIDED)**

NAME	FAX #

BILLING

☐ Insurance ☐ Patient ☐ Client

PRIMARY INSURANCE INFORMATION

Insurance Company

Contract/ID/Policy #	Group #

Name of Insured

Employer

Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other:

SECONDARY INSURANCE INFORMATION

Insurance Company

Contract/ID/Policy #	Group #

Clinical History

☐ History of leukemia
☐ History of lymphoma
☐ History of - R/O myeloma
☐ History of cytopenias (Specify below)

Relevant Clinical History

Other pertinent history:

Chemotherapy: ☐ Yes ☐ No
Last Date:

Biologics: ☐ Rituximab

Growth Factor: ☐ Yes ☐ No
Name of GF / Last Given:

Previous Radiation Therapy: ☐ Yes ☐ No
Last Date:

Type Of Specimen

☐ Peripheral Blood * (Green or Lavendar top)

☐ Bone Marrow * (Green or Lavendar top) Location:

☐ Fluid Specify site and type of specimen:

☐ Lymph Node (RPMI) Site:

☐ Other Tissue (RPMI) Site:

☐ Fine Needle Aspiration (RPMI) Site:

* Please send a copy of the most recent CBC & differential, and a peripheral smear.

Testing Requested

☐ Flow Cytometry Evaluation - Major concern for: ☐ Blasts ☐ Lymphoid Cells ☐ Other:

☐ Bone Marrow Smears For Interpretation

☐ Diagnostic Evaluation Of Peripheral Blood

☐ Bone Marrow Biopsy For Interpretation

☐ Additional Tests:

Cytogenetic Studies: Please complete a separate Genetic Diagnostic Labs (GDL) test requisition form and follow their specimen collection instructions.

Comments / Additional Instructions:

Top (White) Lab Copy - Bottom (Yellow) Client Copy ***Additional Note: Please refer to the back side of requisition for important specimen requirement information.***