UPMC LIFE CHANGING MEDICINE

Hematopathology Testing Service
Bone Marrow/Blood/Body Fluid Specimens

Deliver To:
Clinical Flow Cytometry Laboratory
3477 Euler Way, Room 9032
Pittsburgh, PA 15213
Tel: (412) 864-6173 Fax: (412) 864-6102

PATIENT INFORMATION – Complete all fields. Attach patient insurance/demographic information. PLEASE PRINT.

Last Name	First Name	MI	SSN/MRN

☐ Outpatient ☐ Inpatient – Room#_____	Birthdate	Sex ☐ M ☐ F	ICD 10 Code

REPORTING INFORMATION – Complete all fields.

Requesting Physician	Phone (including area code)	Fax (including area code)

Institution Name	Copy To

Name of person filling out form:	Phone #:

COLLECTION DATE & TIME:	**COLLECTION TECH**:

DIAGNOSTIC INFORMATION / INDICATION FOR TESTING – Required

PB/ CLINICAL ABNORMALITIES: ☐ Neutropenia ☐ Leukocytosis ☐ Eosinophilia ☐ Lymphadenopathy ☐ Blasts
☐ Anemia ☐ Thrombocytopenia ☐ Lymphocytosis ☐ Thrombocytosis ☐ Splenomegaly ☐ Other:_____

ACUTE LEUKEMIA:	**OTHER MYELOID NEOPLASMS**	**MATURE B-CELL NEOPLASMS:**	**MATURE T-CELL NEOPLASMS:**	**PLASMA CELL NEOPLASMS:**
☐ AML	☐ MDS	☐ Burkitt	☐ AITL	☐ Myeloma
☐ APL	☐ MPN	☐ CLL	☐ T-LGL	☐ Monoclonal Gammopathy
☐ B-ALL	☐ CML	☐ DLBCL	☐ T-PLL	**OTHER:**
☐ T-ALL	☐ PV / PMF / ET	☐ Follicular	☐ MF/Sezary Syndrome	☐ **HODGKIN LYMPHOMA**
☐ UNCERTAIN	☐ MDS / MPN	☐ Mantle Cell	☐ Other:_____	☐ **MASTOCYTOSIS**
	☐ CMML	☐ Marginal Zone		
	☐ Other:_____	☐ Other:_____		

DISEASE PHASE (If applicable): ☐ Presentation ☐ Post Therapy ☐ Recurrence

Additional Clinical Information:	**ANTI-NEOPLASTIC THERAPIES:**	Specify Type	Last Date
	☐ Chemotherapy		
	☐ Ag Directed (MAB/CAR-T) RX		
Medications:	☐ Other		
	☐ Growth Factor		
	☐ Radiation		

SPECIMEN INFORMATION – Required

Type of Specimen: ☐ Peripheral Blood ☐ Fluid:
☐ Bone Marrow: ☐ Right Iliac Crest ☐ Left Iliac Crest Type/Site:_____

PLEASE SEND A COPY OF THE MOST RECENT CBC & DIFFERENTIAL AND A PERIPHERAL SMEAR

TESTING REQUESTED – Required

BONE MARROW INTERPRETATION: Includes peripheral blood interpretation, if available.
☐ Bone Marrow Smears for Interpretation ☐ Bone Marrow Particle Prep (yellow top/ACD tube)
☐ Bone Marrow Biopsy for Interpretation ☐ Iron Stain ☐ Other _____
Ancillary testing will be determined by pathologist unless otherwise indicated by checking this box ☐

PERIPHERAL BLOOD INTERPRETATION: Without bone marrow - Please send 2 PB smears along with current CBC report.
☐ Diagnostic evaluation of peripheral blood ☐ Sezary Cell Evaluation

FLOW CYTOMETRY TESTING:
☐ Leukemia Panel ☐ PNH ☐ T-Lymph Subset Panel
☐ Lymphoma Panel ☐ ALPS Evaluation ☐ CD4+ Only Evaluation
☐ R/O Myeloma ☐ Sezary Cell Evaluation ☐ Other(Specify):_____
☐ R/O LGL ☐ CGD (NOBA) Evaluation

MRD
☐ Plasma Cell Myeloma: (pt MUST be in CR/VGPR)
→ **ATTESTATION SIGNATURE** (required):_____
☐ B-ALL (Flow) COG# (if applicable):_____
☐ Other:_____

MOLECULAR ONCOLOGY TESTING
☐ DNA/RNA Storage ☐ Other - MUST complete Molecular Oncology Test Requisition

CYTOGENETICS TESTING: ☐ Sent Separately To Magee
☐ Culture and Hold ☐ Cytogenetics Analysis (CLASSICAL) ☐ Other – MUST complete Pittsburgh Cytogenetics Lab Requisition