HEMATOLOGY / ONCOLOGY PATHOLOGY REQUISITION

MPA
MORRISTOWN PATHOLOGY ASSOCIATES
MORRISTOWN, NJ • 973-971-5289

PATIENT

NAME: Last / First

STREET / APT #:

CITY / STATE / ZIP:

PHONE #:	DATE OF BIRTH:
SOCIAL SECURITY #:	SEX: ☐ Male ☐ Female

BILLING INFORMATION — ATTACH INSURANCE FACE SHEET IF AVAILABLE

INSURANCE - PRIMARY *Please attach copy of insurance card*

CARRIER:	SUBSCRIBER:	DOB:
☐ Commercial ☐ HMO ☐ Medicare ☐ Medicaid	INSURANCE ID #:	GP #:

INSURANCE - SECONDARY

CARRIER:	INSURANCE ID #:

SPECIMEN TYPE: ☐ BM ☐ PB ☐ FNA ☐ Lymph Node ☐ Body Fluid

☐ BONE MARROW MORPHOLOGY

(Core & Clot in Formalin, Smears in Slide Carrier)

- ☐ Analysis: Core / Clot / Smears
- ☐ Please Return Smears

☐ FLOW CYTOMETRY (FCM)

FCM PANELS
(2mL heparinized/EDTA marrow, 5mL heparinized/EDTA blood)

☐ ACUTE LEUKEMIA	AML / ALL
☐ MYELODYSPLASIA	MDS
☐ PNH - PERIPHERAL BLOOD	
☐ MYELOPROLIFERATIVE	CML / Other
☐ LYMPHOMA B & T / CHRONIC LEUKEMIA	(CLL)
☐ PLASMA CELL DYSCRASIA	
☐ OTHER: ______________________	

☐ CYTOGENETICS (CG)

(2mL heparinized/EDTA marrow, 5mL heparinized/EDTA blood)

☐ REFLEX TO FISH PROBES IF CG NEGATIVE

** Each Test Can Be Ordered Separately Or As A Panel*

PROCEDURE DATE:

PHYSICIAN

DOCTOR NAME:

PRE-OPERATIVE DX/ ICD 9 CODE:

CLINICAL INFO:

☐ MOLECULAR STUDIES

☐ FISH PROBES

☐ BCR-ABL t(9;22)	CML/AML/ALL
☐ PML-RARA t(15;17)	AML-M_3/APL
☐ CBFB inv(16)	AML-M_4eo
☐ AML_1/ETO t(8;21)	AML-M_2
☐ BCL_1/IGH t(11;14)	MCL
☐ IGH/BCL_2 t(14;18)	FCL
☐ MDS PANEL*	11q23, +8, -5/5q-, -7/7q-, 20q-
☐ MYELOMA PANEL*	RB1, p53, (+5/9/15, t(11;14), t(4;14),14q32
☐ CLL PANEL*	+12, ATM, t(11;14), RB1, p53
☐ MDS PANEL, Reflex if CG Neg	
☐ BCL6/IGH	
☐ MYC/IGH	
☐ UroVysion	

☐ PCR / RT-PCR

☐ RT-PCR, bcr/abl	(lavender tube)
☐ PCR, JAK-2	(lavender tube)
☐ RT-PCR, PML - RARA t(15;17)	(lavender tube)
☐ RT-PCR, CBFB inv(16)	(lavender tube)
☐ PCR, IGH B-cell clonality	(lavender tube)
☐ PCR, T gamma T-cell clonality	(lavender tube)
☐ PCR, Flt3	(lavender tube)
☐ RT-PCR/PCR, Other	(lavender tube)

☐ DNA SEQUENCING/MUTATION ANALYSIS

☐ CLL: *IGHV* Mutation

PATIENT AUTHORIZATION: ______________________
PATIENT SIGNATURE

PHYSICIAN SIGNATURE ______________ UPIN #

NOT PART OF PERMANENT RECORD

LAB USE ONLY ☐ Core ☐ Clot ☐ Aspirate / G / L ☐ Smears ______________