Flow Cytometry Requisition

ACCOUNT INFORMATION

Account name: _____

Address: _____ **City:** _____ **State:** _____

Zip code: _____ **Ph:** _____ **Fax:** _____

Flow Cytometry Laboratory
2330 Inwood Road, Suite EB3.304
Dallas, Texas 75390
LAB PHONE: 214-648-0930
LAB FAX: 214-648-0940
CUSTOMER SERVICE: 214-645-7057
TOLL FREE: 877-887-8136
url:www.veripathlabs.com
CLIA #: 45D-0659587
CAP #: 2723201

UT SOUTHWESTERN MEDICAL CENTER

VERIPATH LABORATORIES

www.veripathlabs.com

REQUIRED ORDER INFORMATION

BILL TO: ☐ Facility / Client ☐ Patient / 3rd party **– Billing information must be provided**

Patient Name: (Last, First, Middle)

Mother's Name: (if infant)

Date of Birth: | Sex: | Patient ID / MR#:

Hospital Inpatient Y / N | Collection Date: | Collection Time: AM : PM

Ordering Physician (Full Name): | NPI:

Phone: | Pager: | FAX:

Clinical Indication for Tests Ordered:

PATIENT/3RD PARTY BILLING INFORMATION

ICD-9 Code(s)

Medicare patients with non-covered diagnoses must sign Advanced Beneficiary Notice (ABN) available at www.veripathlabs.com or by calling customer service at 214-645-7057 or toll free 877-887-8136 ☐ Signed ABN included

ICD-9 Codes applicable to each and every test requested should come only from the ordering physician, represent the reason for the test order at the time of order, and be supported by the patient's medical record. Physicians should order only tests that are medically necessary for the diagnosis or treatment of the patient. Tests ordered should be single laboratory tests appropriate for the patient's medical condition. Tests for screening purposes may be ordered, but may not be reimbursed.

Insured/Responsible Party Name: (if different from patient-Last, First, Middle) | Date of Birth:

Patient's relationship: ☐ Self ☐ Spouse ☐ Dependent ☐ Other | Responsible Party Address: (street, city, State, zip)

Sex: | Phone:

Employer's Name: | Employer's Phone:

Insurance Co. Name: | Insurance Co. Phone:

Insurance Co. Address:

Policy #: | Group #:

☐ Medicare ☐ HMO ☐ Other ☐ Medicaid ☐ PPO | Member ID#:

Referral Authorization/Precertification #:

Name: | Date/Time:

SPECIMEN INFORMATION

☐ Bone Marrow
☐ Peripheral Blood
☐ CSF
☐ Body Fluid (source): _____
☐ Biopsy (source): _____
☐ Tissue (source): _____
☐ FNA (source): _____
☐ Other: _____

NOTE: Submit one specimen per container CLEARLY LABELED.
Submit smear and CBC copy when requesting analysis of marrow or blood.

CLINICAL INFORMATION

Primary Physician: (if different from above)

Phone: | Pager: | FAX:

FOR IMMUNOPHENOTYPING CASES ONLY

☐ Lymphadenopathy ☐ Mediastinal Mass ☐ Splenomegaly

FOR ALL CASES

Current Therapy

☐ Chemotherapy
☐ Growth Factor
☐ Immunotherapy: _____
☐ Other: _____

Current Infection

☐ HIV
☐ Other: _____

TEST REQUESTED

IMMUNOPHENOTYPING:

☐ Leukemia/Lymphoma Immunophenotyping

☐ PNH Panel (Paroxysmal Nocturnal Hemoglobinuria)

☐ ALPS (Autoimmune Lymphoproliferative Syndrome)

☐ BAL (Bronchoalveolar Lavage) CD4:CD8

☐ Process and hold sample for Immunophenotypic analysis (call next day with instructions)

☐ Other Markers: _____

IMMUNODEFICIENCY WORKUP:

Must Provide:

WBC count _____ $10^3/\mu L$ Lymphs _____ % Atypical Lymphs _____ %

☐ T & B Cell subset quantification, including NK's (CD3, CD4, CD8, CD19, CD16+56)
☐ CD4 quantification (HIV monitoring)
☐ CD3 quantification (Transplant monitoring)
☐ T-Cell subset quantification (CD3, CD4, CD8)
☐ Extended Lymph Subset Panel
☐ Severe Combined Immunodeficiency (SCID)
☐ B-Cell Total Count (CD19)
☐ B & NK Cell Subset Panel (CD19 & CD16+56)
☐ NK Cell Total Count (CD16+56)

VERIPATH USE ONLY

Transport Container: **Total # of specimens:** _____
___Yellow ___Green ___Purple ___Syringe ___Conical ___Red ___Blue ___Cup
___Trans Tube ___Block ___Slides ___Formalin ___Other: _____

Transport Conditions:
☐ Frozen ☐ Slushy
☐ Refrig ☐ Room Temp

Destination: ☐ Other _____
☐ Coag ☐ Cytogen ☐ Hemepath
☐ Flow ☐ Hist ☐ Mol Dx

Initials: