

# Flow Cytometry Requisition



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 CLIA #45D-0659587, CAP #2723201

VERIPATH LABORATORIES

www.veripathlabs.com

**ACCOUNT INFORMATION**

Account name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip code: \_\_\_\_\_ Ph: \_\_\_\_\_ Fax: \_\_\_\_\_

**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: \_\_\_\_\_

Physician Signature: \_\_\_\_\_  
**REQUIRED FOR MEDICARE/MEDICAID PATIENTS**

Phone: \_\_\_\_\_ Pager: \_\_\_\_\_ FAX: \_\_\_\_\_

Clinical Indication for Tests Ordered: \_\_\_\_\_

**SPECIMEN INFORMATION**

Bone Marrow  Body Fluid (source): \_\_\_\_\_

Peripheral Blood  Biopsy (source): \_\_\_\_\_

CSF  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

**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: \_\_\_\_\_

**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: \_\_\_\_\_

**FOR ALL CASES**

**Current Therapy** **Current Infection**

Chemotherapy  HIV

Growth Factor  Other: \_\_\_\_\_

Immunotherapy: \_\_\_\_\_

Other: \_\_\_\_\_

**IMMUNODEFICIENCY WORKUP:**

**Must Provide:**

WBC count \_\_\_\_\_ 10<sup>3</sup>/μL 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

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: \_\_\_\_\_ Transport Conditions: \_\_\_\_\_ Destination:  Other \_\_\_\_\_ Initials: \_\_\_\_\_

Yellow  Green  Purple  Syringe  Conical  Red  Blue  Cup  Frozen  Slushy  Coag  Cytogen  Hemepath

Trans Tube  Block  Slides  Formalin  Other: \_\_\_\_\_  Refrig  Room Temp  Flow  Hist  Mol Dx