

Children's Hospital Los Angeles  
 Alexander R. Judkins, MD  
 Department of Pathology & Laboratory Medicine  
 Pathologist-in-Chief and Laboratory Director  
 4650 Sunset Boulevard  
 Los Angeles, CA 90027  
 Phone: 323.361.2423, 877.543.9522  
 Fax: 323.361.6157  
 CLIA Number: 05D0542989  
 California State License CLF260  
 CAP Number: 2266301



INSTITUTIONAL ACCOUNT

**Ship To:**

Department of Pathology and Laboratory Medicine  
 Children's Hospital Los Angeles  
 4650 Sunset Blvd.  
 Duque Bldg., 2nd Floor, Room 2-290  
 Los Angeles, CA 90027

**MRD BY FLOW CYTOMETRY TEST REQUISITION**

**All information must be completed before sample can be processed.**

**PATIENT INFORMATION**

\_\_\_\_\_  
 Last Name First Name MI  
 DOB (MM/DD/YYYY): \_\_\_\_\_ Gender: ☐ M ☐ F ☐ Unknown  
 MRN/ ID Number: \_\_\_\_\_

**CLINICAL INFORMATION**

Clinical diagnosis or Indication for test: \_\_\_\_\_  
 \_\_\_\_\_

Therapy given: \_\_\_\_\_

☐ ICD-10 Code: \_\_\_\_\_

**RELEVANT TREATMENT HISTORY**

- ☐ Pretreatment ☐ Anti-CD19 Therapy (Blinatumumab, CART, etc.)  
☐ End of Induction ☐ Anti-CD20 Therapy (Rituxumab, etc.)  
☐ End of Consolidation ☐ Anti-CD22 Therapy (Inotuzumab, CART, etc.)  
☐ Pre-transplant ☐ Anti-CD38 Therapy (Daratumumab, etc.)  
☐ Post-transplant, Day \_\_\_\_\_  
☐ Other \_\_\_\_\_

**SAMPLE INFORMATION**

Date of Collection (MM/DD/YYYY): \_\_\_\_\_

Time Collected: \_\_\_\_\_ ☐ AM ☐ PM

Specimen Type:

- ☐ Blood (EDTA or EDTA in Shipping Media)  
☐ Bone Marrow (Sodium Heparin, EDTA or EDTA in Shipping Media)  
☐ CSF - (Send refrigerated in Transfix strongly preferred or 1:1 RPMI by volume)  
☐ Other (Please Specify) \_\_\_\_\_

**TEST(S) REQUESTED**

Please include report with diagnostic Immunophenotype

- ☐ **B-ALL MRD by Flow Cytometry, (COG)**  
☐ Day 8 (peripheral blood)  
☐ End of Induction - Day 29 (bone marrow)  
☐ Other, e.g. End of Consolidation (bone marrow)

**NOTE:** If the time point is not specified as Day 8 or End of Induction, testing will include additional evaluation for CD19 negative leukemia.

☐ **T-ALL MRD by Flow Cytometry**

☐ **AML MRD by Flow Cytometry**  
☐ Megakaryoblastic

☐ **MPAL MRD by Flow Cytometry (specify lineages)**  
☐ B lineage ☐ T lineage ☐ Myeloid lineage

☐ **CRLF2 evaluation by Flow Cytometry with reflex to CRLF2 FISH if positive**

☐ **Other by Flow Cytometry (specify) \_\_\_\_\_**

**REPORTING INFORMATION**

Hospital/Laboratory Name: Hospital of the University of Pennsylvania  
 William Pepper Lab

Ordering Physician: \_\_\_\_\_

Address: 3400 Spruce Street—7th Floor Founders Building

City: Philadelphia State: PA Zip Code: 19104

Phone: 215-662-4809 Secure Fax: 215-349-8294

☐ Send Duplicate Report to:

Physician: \_\_\_\_\_

NPI: \_\_\_\_\_

Address: \_\_\_\_\_

**BILLING INFORMATION**

**PLEASE NOTE:** We only bill the submitting institution. We do not bill third parties.

Referring Institution

CHLA Account Number\* : **1793**

Hospital/Laboratory Name: **Hospital of the University of Pennsylvania  
 William Pepper Lab**

Address: 3400 Spruce Street

City: Philadelphia State: PA Zip Code: 19104

Accounts Payable Contact Name: Lynn Vespasiani

Phone: 215-662-7967 Fax: 215-349-8294

Email: Lynn.Vespasiani@pennmedicine.upenn.edu

**SEE PAGE 2 FOR SAMPLE REQUIREMENTS AND  
 SHIPPING INSTRUCTIONS.**

**For Internal Use Only:**

Date Received: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time Received: \_\_\_\_: \_\_\_\_ AM /PM

Technician: \_\_\_\_\_

Children's Hospital Los Angeles  
Alexander R. Judkins, MD  
Department of Pathology & Laboratory Medicine  
Pathologist-in-Chief and Laboratory Director  
4650 Sunset Boulevard  
Los Angeles, CA 90027  
Phone: 323.361.2423, 877.543.9522  
Fax: 323.361.6157  
CLIA Number: 05D0542989  
California State License CLF260  
CAP Number: 2266301

**Ship To:**

Department of Pathology and Laboratory Medicine  
Children's Hospital Los Angeles  
4650 Sunset Blvd.  
Duque Bldg., 2nd Floor, Room 2-290  
Los Angeles, CA 90027

**SAMPLE REQUIREMENTS**

Each specimen must be labeled with two patient identifiers; patient name or study ID and date of birth. Indicate the specimen type on the tube, either peripheral blood (PB) or bone marrow aspirate (BMA). The patient requisition form must accompany the specimen; the requisition form must contain and match the same two patient identifiers as on the specimen. Note that use of patient name on the specimen tube is not a HIPAA violation.

**BONE MARROW COLLECTION**

Collect 2 to 3 mL bone marrow aspirate from the first pull and immediately transfer from syringe to either an EDTA or Sodium Heparin tube. Use of shipping media (RPMI + EDTA) can enhance specimen viability. Please do not ship syringes

**PERIPHERAL BLOOD COLLECTION**

Peripheral blood is drawn into a 5 mL EDTA tube, minimum volume is 2 mL. Mix well. Use of shipping media (RPMI + EDTA) can enhance specimen viability. Please do not ship syringes.

**CEREBROSPINAL FLUID**

Collect or transfer 1-2 mL of CSF directly into a 5 mL Transfix tube, preferably at bedside. Mix and refrigerate. This is the preferred method. Alternatively, CSF can be mixed 1:1 with RPMI by volume and refrigerated. Ship refrigerated for either method to preserve antigenic and cellular integrity.

**SHIPPING AND HANDLING INSTRUCTIONS****TEMPERATURE:**

All samples should be shipped at **room temperature**. Samples shipped during extremely hot weather periods can be packaged with a cold pack (not an ice pack).

**GENERAL INSTRUCTIONS:**

1. Please make every effort to ship specimens on the day they are collected to maximize cell viability, but specimens that are shipped the following day will also be accepted.
2. We accept samples Monday through Friday from 7:00 AM to 4:00 PM PST. We also accept samples on Saturdays from 7:00 AM to 2:00 PM PST. Holidays and weekends should be taken into consideration before mailing samples.
3. To ensure sample integrity, use of the following delivery priorities is highly recommended.  
FedEx: First Overnight  
UPS: Next Day Air Early AM
4. We will notify you within 24 hours of receipt if we are unable to perform testing due to compromised sample integrity.
5. Please notify us ASAP in writing if you wish to cancel a test. Cancellations cannot be accepted once testing has been initiated.
6. **Your specimen is important to us. Please email the tracking number to [PLMTrack@chla.usc.edu](mailto:PLMTrack@chla.usc.edu) at the time of shipment and include contact information to be used in the event your sample is not received.**

**BILLING INFORMATION**

1. For billing inquiries, please call (877) 543-9522.
2. If you are interested in opening an account with Children's Hospital Los Angeles, please contact our Laboratory Service Center at (877) 543-9522. Please be prepared to provide the following information:
  - a. Name of Institution
  - b. Address
  - c. Phone/Fax Number
  - d. Laboratory Contact Name and phone number
  - e. Accounts Payable Contact Name and phone number
3. Third party billing is not offered at this time.

**CONTACT US**

For all other inquiries, please contact our Laboratory Service Center at:

**(877)KIDZ-LAB or (877) 543-9522**

Visit our website at:

**[www.chla.org/laboratory-medicine](http://www.chla.org/laboratory-medicine)**