Flow Cytometry Requisition

ACCOUNT INFORMATION

Acct: MCTYD Medical City Dallas Hospital
7777 Forest Lane Building A,Suite # A200
Dallas, TX 75230
Phone: 972-566-7717 Fax: 469-484-2355

UT SOUTHWESTERN MEDICAL CENTER
VERIPATH LABORATORIES
5323 Harry Hines Blvd U5.100
Dallas, Texas 75390
PHONE: 214-645-7057
Toll Free: 877-887-8136
FAX: 214-645-7035
CLIA #45D-0659587, CAP #2723201 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 ☐ 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

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

☐ B-Cell Total Count (CD19)

☐ B & NK Cell Subset Panel (CD19 & CD16+56)

☐ NK Cell Total Count (CD16+56)

VERIPATH USE ONLY	Transport Container: ___Yellow ___Green ___Purple ___Syringe ___Conical ___Red ___Blue ___Cup ___Trans Tube ___Block ___Slides ___Formalin ___Other: Total # of specimens:____	Transport Conditions: ☐Frozen ☐Slushy ☐Refrig ☐Room Temp	Destination: ☐Other_____ ☐Coag ☐Cytogen ☐Hemepath ☐Flow ☐Hist ☐Mol Dx	Initials: