JOHNS HOPKINS MEDICAL LABORATORIES
401 N. Broadway – Baltimore, MD 21231
Phone: 410-614-2968, Fax: 410-614-2912

☐ Bill Institution /Account Number: **CBE 1 0 6 2 0 3 7 8 2**
Institution will be billed, but please provide Patient Demographic information form.

State of Maryland License #471
CLIA License #21D0680509

(REQUIRED): **Institution's Name and Mailing Address:**	**Patient's Last Name*:**
	Patient's First Name*:
	Patient's Middle Name:
***Institution Billing Name and Address:** Univ. of Rochester Medical Center, Central Laboratories/Reference Lab, 77 Ridgeland Road, Rochester, NY 14623	**Date of Birth*:** ☐☐-☐☐-☐☐☐☐ ☐M ☐F (Month Day Year) ***All Info is Required**
	Location: See CBE account # / **Collection Date*:** / **Collection Time*:**
ORDERING PROVIDER'S NAME: (REQUIRED)	**ORDERING PROVIDER'S CONTACT NUMBER AND ADDRESS: (REQUIRED)**
ORDERING PROVIDER'S NPI: (REQUIRED)	
Provider's Authorized Signature:	**(REQUIRED) CONTACT NAME AND PHONE NUMBER WHO CAN BE REACHED OFF HRS. & SATURDAY FOR QUESTIONS:**

Flow Cytometry

THE FOLLOWING SECTIONS MUST BE COMPLETED FOR ACCURATE AND RAPID ANALYSIS.

Clinical Information: Please provide pertinent clinical history and physical findings. **Please submit a copy of diagnostic report if possible.**

Reason for ordering Flow Cytometry:

If First Time Diagnosis:
- ☐ **Blasts Present**
- ☐ **Lymphocytosis**
- ☐ **Lymphadenopathy or mass**
- ☐ **Cytopenia(s) (specify)** _____
- ☐ **Plasmacytosis or monoclonal paraprotein**
- ☐ **Other(specify)**_____

Check if known prior diagnosis:
- ☐ **MDS**
- ☐ **AML**
- ☐ **Pre B ALL**
- ☐ **T Cell ALL/lymphoblastic lymphoma**
- ☐ **B cell NHL**
- ☐ **CLL**
- ☐ **LGL**
- ☐ **Burkitt's**
- ☐ **Peripheral T Lymphoma**

Check if MRD assessment desired
Days Post Treatment _____
- ☐ **Pre B-ALL**
- ☐ **T-ALL**

Anti-CD20 Therapy? Yes No
Anti-CD19 Therapy? Yes No
Other_____

Other Relevant Disease: _____

Specimen Information: Please include WBC value and percent lymphocytes/ or %blasts) from PB

WBC _____/uL **% Lymphocytes** _____% **%Blasts (if applicable)** _____%

Test Requested*: Please place an (X) next to those tests you wish to order*.

☐ (WBFLO) Flow Cytometry- WHOLE BLOOD (EDTA-Purple Top)
☐ (BMFLO) Flow Cytometry- BONE MARROW (Sodium Heparin- Green Top)
☐ (PNH) FLAER/CD59 for PNH - ***Blood Only!***

☐ (CFFLO) Flow Cytometry- CSF
☐ (OFLOW) Flow Cytometry OTHER, please specify_____
☐ (OFLOW) Flow Cytometry- FNA-Fine Needle Aspirate, indicate site_____
☐ (LNFLO) Flow Cytometry- LYMPH NODE /site

Lab Use Only	**Specimen Delivery Address:**
Date Received: ___/___/___	Johns Hopkins Medical Institution
Time Received: _____ ( ) am ( ) pm	Weinberg Building, Room 2300
Condition of Specimen: ( ) Good ( ) Unsatisfactory	Flow Cytometry Laboratory
ICD 10 CODE:	401N. Broadway
	Baltimore, MD 21231-2410 Attn.: Michael Borowitz,M.D.,Ph.D