Hematopathology / Cytogenetics / Flow Cytometry Laboratory Requisition
617-667-2167
617-667-7167

Clinical Laboratories

Beth Israel Deaconess Medical Center, Boston, MA 02215
Phone: 617-667-(LABS) (617-667-5227)

Ordering RN or MD (if other than below)		MEDICAL RECORD #	
Responsible Staff Physician	Telephone/Beeper:	NAME	
PRINT OR TYPE NAME	RESPONSIBLE PHYSICIAN ONLY	SEX	
		DATE OF BIRTH	
		Date ordered	Date & time collected ❍AM ❍PM
		Phlebotomist	
		Grant #	List all relevant ICD9 codes for tests being ordered
Send extra report to:	Name and address	**Responsible Attending Physician's Signature**	

Instructions: **LABEL SPECIMEN** fully, including name, unit #, collection time and collector's signature. **FILL IN REQUISITION (UNSHADED AREAS) COMPLETELY. CHECK TESTS DESIRED. Deliver to Lab Control, Finard 305.**

Clinical History / Indication

Laboratory Values if non-BIDMC labs

Hct _____
Hb_____
MCV_____

Differential
_____
WBC _____
PLT_____
MCHC _____

Fe _____
TIBC_____
Ferritin_____
B12 _____
Folate _____
LDH _____
Bilirubin _____
BUN _____

Pertinent Physical Exam

❒ Lymphadenopathy
❒ Splenomegaly
❒ Hepatomegaly
❒ Cutaneous Lesion
❒ Other:_____

Indications

❒ Acute Lymphoid Leukemia
❒ Acute Myeloid Leukemia
❒ Chronic Lymphocytic Leukemia
❒ Chronic Myeloid Leukemia
❒ Chronic Myeloproliferative syndrome
❒ Lymphoma (NHL)
❒ Hodgkin Lymphoma (HL)
❒ Myelodysplastic syndrome (MDS)
❒ Anemia
❒ Leukopenia
❒ Thrombocytopenia
❒ Other_____

Disease Status

❒ Undiagnosed
❒ Untreated
❒ Partial Remission
❒ Remission
❒ Relapsed
❒ Not Stated

Therapy History

❒ Chemotherapy
❒ Radiation
❒ Immunotherapy
❒ Growth Factor
❒ Allo BMT
Sex-mismatched
Sex-matched
❒ Auto BMT
❒ DLI

SPECIMEN TYPE / TESTS REQUESTED

Specimen Type:
❒ Bone Marrow Core Biopsy Right _____ Left _____Iliac Crest
❒ Bone Marrow Aspirate for Hematopathology (Purple top tube-EDTA)
❒ Bone Marrow Aspirate for Cytogenetics (Green top tube-sodium heparin)
❒ Bone Marrow Aspirate for Culture (Pediatric isolator tube)
❒ Peripheral Blood for Flow Cytometry (Purple top tube-EDTA)
❒ Peripheral Blood for Cytogenetics, FISH (Green top tube-sodium heparin)
❒ CSF for flow cytometry
❒ Flow cytometry; FNA, other (site)_____
❒ Other (specify)_____

Cytogenetics:
(Emergency, page 30805)
❒ Karyotype
❒ FISH
❒ Other
Specify: _____

Molecular:
❒ B cell clonality
❒ T cell clonality
Outside laboratory:
❒ BCR/ABL (CML, ALL)*
❒ PML/RARA (Acute Promyelocytic L)*
❒ Other (specify)_____

Flow Cytometry:
❒ Acute Leukemia
❒ Acute Leukemia follow up
❒ Chronic Leukemia
❒ Cutaneous T cell Lymphoma
❒ Large Granular Lymphocyte Leukemia
❒ Lymphoma type _____
❒ Hairy cell
❒ PNH
❒ Other_____

Gross Description (Lab Use Only)

SEND OUT TESTING

❒ Send Out Specimen (List Test)*:
❒ Cytogenetics
❒ Molecular
❒ Other: _____

SEND OUT Information

Reference Lab:_____
_____
Address:_____
_____
Telephone:_____

ICD-9-CM CODES AND LABORATORY TEST ORDERS:

- ICD-9 codes MUST BE recorded on the requisition for laboratory work to be performed, regardless of insurer.
- When ordering tests for which Medicare reimbursement will be sought, order only tests that are medically necessary for the diagnosis or treatment of a patient, rather than for screening purposes.

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