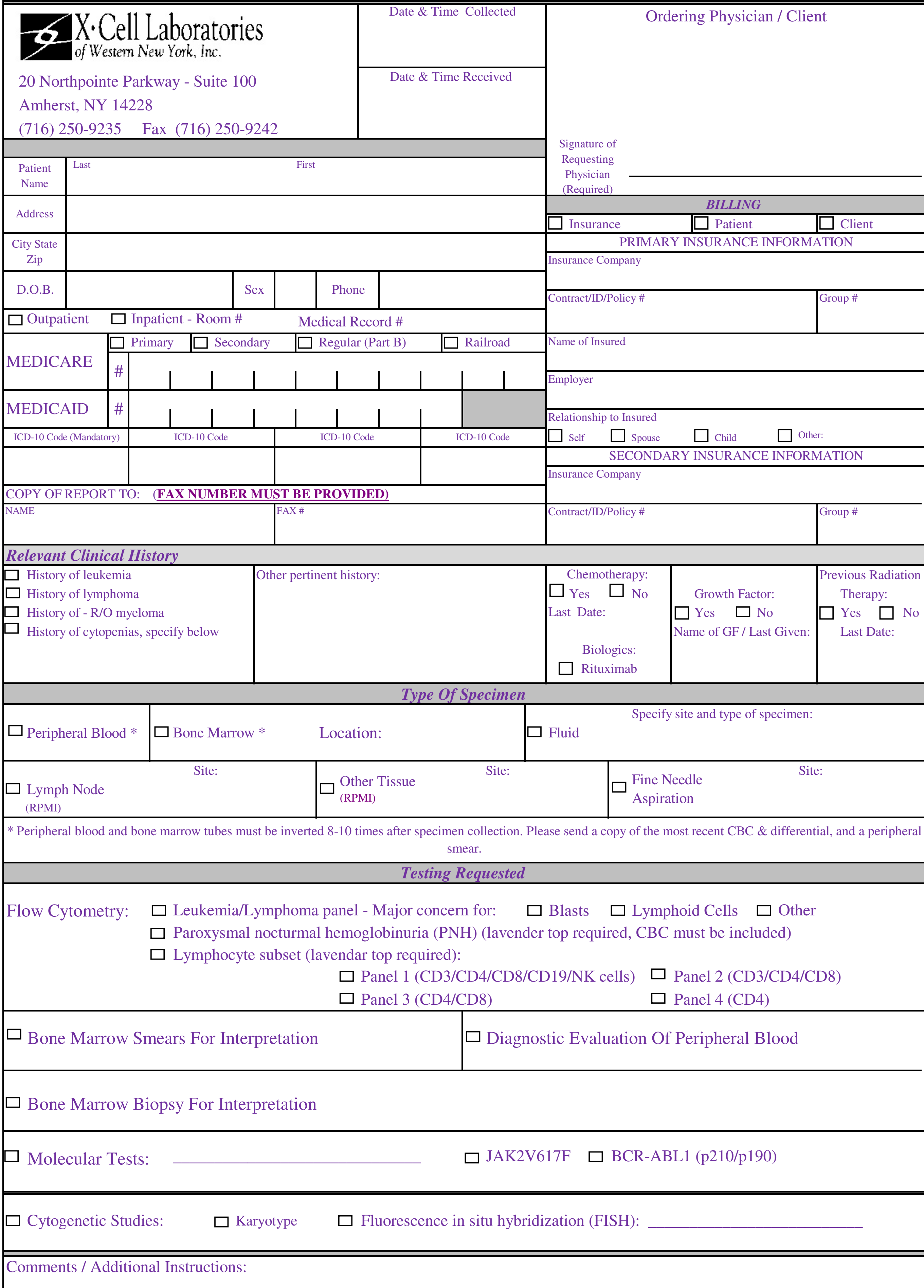
HEMATOPATHOLOGY TESTING SERVICES REQUISITION

The space above this line is for laboratory use only.



X·Cell Laboratories of Western New York, Inc.

20 Northpointe Parkway - Suite 100
Amherst, NY 14228
(716) 250-9235 Fax (716) 250-9242

Date & Time Collected

Date & Time Received

Ordering Physician / Client

Signature of Requesting Physician (Required) ______________________

Patient Name	Last	First
Address		
City State Zip		

D.O.B.		Sex		Phone	

☐ Outpatient ☐ Inpatient - Room # Medical Record #

MEDICARE ☐ Primary ☐ Secondary ☐ Regular (Part B) ☐ Railroad
#

MEDICAID #

ICD-10 Code (Mandatory)	ICD-10 Code	ICD-10 Code	ICD-10 Code

COPY OF REPORT TO: **(FAX NUMBER MUST BE PROVIDED)**

NAME	FAX #

BILLING

☐ Insurance ☐ Patient ☐ Client

PRIMARY INSURANCE INFORMATION

Insurance Company

Contract/ID/Policy # Group #

Name of Insured

Employer

Relationship to Insured
☐ Self ☐ Spouse ☐ Child ☐ Other:

SECONDARY INSURANCE INFORMATION

Insurance Company

Contract/ID/Policy # Group #

Relevant Clinical History

☐ History of leukemia
☐ History of lymphoma
☐ History of - R/O myeloma
☐ History of cytopenias, specify below

Other pertinent history:

Chemotherapy: ☐ Yes ☐ No
Last Date:
Biologics:
☐ Rituximab

Growth Factor: ☐ Yes ☐ No
Name of GF / Last Given:

Previous Radiation Therapy: ☐ Yes ☐ No
Last Date:

Type Of Specimen

☐ Peripheral Blood * ☐ Bone Marrow * Location: ☐ Fluid Specify site and type of specimen:

☐ Lymph Node (RPMI) Site: ☐ Other Tissue (RPMI) Site: ☐ Fine Needle Aspiration Site:

* Peripheral blood and bone marrow tubes must be inverted 8-10 times after specimen collection. Please send a copy of the most recent CBC & differential, and a peripheral smear.

Testing Requested

Flow Cytometry: ☐ Leukemia/Lymphoma panel - Major concern for: ☐ Blasts ☐ Lymphoid Cells ☐ Other
☐ Paroxysmal nocturmal hemoglobinuria (PNH) (lavender top required, CBC must be included)
☐ Lymphocyte subset (lavendar top required):
☐ Panel 1 (CD3/CD4/CD8/CD19/NK cells) ☐ Panel 2 (CD3/CD4/CD8)
☐ Panel 3 (CD4/CD8) ☐ Panel 4 (CD4)

☐ Bone Marrow Smears For Interpretation ☐ Diagnostic Evaluation Of Peripheral Blood

☐ Bone Marrow Biopsy For Interpretation

☐ Molecular Tests: ______________________ ☐ JAK2V617F ☐ BCR-ABL1 (p210/p190)

☐ Cytogenetic Studies: ☐ Karyotype ☐ Fluorescence in situ hybridization (FISH): ______________________

Comments / Additional Instructions: