HEMATOPATHOLOGY REQUEST FORM



Main Lab: 907-212-3631 Pathology: 907-212-3098 Fax: 907-212-3632

P.O. Box 196604 Anchorage, AK 99519-6604

PLEASE PRINT CLEARLY ALL INFORMATION MUST BE PROVIDED USE BLACK OR BLUE INK ONLY DATE OF BIRTH SEX (REQUIRED):							
PLEASE PRINT CLEARLY ALL INFORMATION MUST BE PROVIDED PATIENT'S FULL LEGAL NAME (REQUIRED)			D USE BLACK OR BLUE INK O	NLY	(REQUIRED)	MALE	
١.^	FATIENT 3 FULL LEGAL NAME (NEQUINED)					, ,	FEMALE
LA	ST:	FIRS	ST.		MI:		OTHER
LA	CLIENT/PHYSICIAN ACCOUNT		INSURANCE	SUBSCRIBER (LAST, FIF		DATE OF	
BIL		PATIENT BILL COMPLETE REQUIR		CODOCHIBER (EXCT, TH	ior, wiiddeej	D/(IE OI	Birtiti
	COMPLETE REQUIRED AREAS	& AREAS BELOW	ALL AREAS				
	GUARANTOR (LAST, FIRST, MIDDLE) (REQUIR	ED EXCEPT FOR MEDICARE)	DATE OF BIRTH	ADDRESS (CITY, STATE	, ZIP)		
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MONDAY	ADDRESS			PHONE #	PAII	IENT RELATIONSHIP	
Ó	CITY/STATE/ZIP CODE:			INSURANCE CO.			
Σ	0117,017112,211 0002.			11.00181102 00.			
2	PT. RELATIONSHIP:			CLAIMS ADDRESS (CITY, STATE, ZIP)			
FOLLOWING							
2	HOME PHONE NO.:	WORK PHONE NO.:		INSURANCE PHONE	INSURANCE/MEMBER F	POLICY # GROUP #	ŧ
6							
Ľ.	Date of Service (Collection):	/	_ Time:	COPY To:			
표	Specimen: Peripheral Blood	☐ Blood Marrow	Aspirate 🗆 Iliac C	Core: ☐ Right ☐ Left			
5	Gleevec: ☐ Yes ☐ No Rit	tuxan: 🗌 Yes 🔲 No	GCSF: 🗆 Y	es 🗆 No			
E	Ancillary Tests: ☐ CBC w/diff a	and slide review	Other:				
UNTIL	Microbiology (Use bone marrow c					□ AFR □ Routi	ne 🗆 Fungus
ည	DIAGNOSIS*	altare collection kit of pr	acc in sterile container	. Obtain kit irom wildrobior	ogy Lab (301) 212-0023).		Tic Tungus
三							
RESULTS	☐ B-Cell Lymphoma C85.10				CLL C91.10	. L C91.00	AML C92.00
~		oliferative D47.1	☐ Myeloma/MG	iUS C90.00			
≽	☐ Hodgkin Lymphoma C81.90	☐ Anemia D6	64.9 Throm	bocytopenia D69.6	Other		
A	*All diagnosis should be provided by the	e ordering physician or th	heir authorized designe	e. For a complete listing o	f ICD-10 codes refer to a c	current version of the	ICD-10-CM Book.
PRELIMINARY	☐ Ancillary testing ordered a	at Pathologist's d	iscretion				
S		_					
뿙	CYTOGENETICS (Na Heparin t	ube at room temp. 7-1	0 ml peripheral bloc	od or 1-2 ml marrow)			
٩	☐ Routine Karyotype			, a or r ==a			
	FISH *NHL = Non-Hodgkin Lymp	homa					
HAVE	☐ CML ☐ B/T ALL ☐ MDS		□ Myoloma/MGHS	C □ Indolont B NUI*	□ Aggressive B NL	IL* ☐ Other	
NOT			-		Aggressive b-IVI	ic Other	
ž	FLOW CYTOMETRY (Na Heparin tube preferred, 72 hour stability. Or EDTA 24 hour stability)						
Ⅎ	☐ Leukemia/Lymphoma ☐ M	yeloma/MGUS	☐ PNH ☐ Sphe	rocytosis 🗆 CLL F	Prognostic Markers		
WILL	☐ CD34 Enumeration ☐ T-Ce	ell Receptor					
S	MOLECULAR STUDIES (EDTA	tube at room temp. 5	mL peripheral blood	or 3 mL marrow.)			
ō	☐ Qualitative BCR/abl ☐ Quar	ntitative BCR/abl	☐ P210 ☐ P190	D □ MYD88 □	CLL Prognostic Panel		
E	☐ B-cell clonality ☐ T-cell clona	ality 🗌 FLT3 mutat	ion 🗆 NPM1	□ Re	eflex if negative to CEBI	PA (check if reflex a	also approved)
Ĭ	· ·	•				,	, ,
	□ Reflex testing JAK2 > CALR > MPL OR □ JAK2 □ Calreticulin □ MPL □ PML – RARA PCR □ Other Additional Test/Comments:						
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≱							
	Pertinent Clinical history:						
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Z							
WARNING: FRIDAY COLLECTION							
>							
	Ordering Provider (Print First and L	ast Name)					
La	b Use Only: Prior testing (flow/molec	cular) ☐ Yes ☐ No.	Lab		Date		
, -~	,	,					

MEDICAL NECESSITY STATEMENT FOR PHYSICIANS

The ordering physician certifies that the tests ordered and to be billed to Medicare are medically necessary and understands that all available tests may be ordered individually and, profiles may, where appropriate, be billed separately. Only tests that the ordering physician believes appropriate for patient care should be ordered. Medicare will pay only for tests that are medically necessary for the diagnosis and treatment of the patient, rather than for screening purposes. ICD-10CM diagnosis code(s) **must** be provided for each test ordered.

AMA Panels						
Comprehensive Metabolic Panel 80053 Sodium Potassium Chloride Carbon Dioxide Glucose Creatinine BUN Calcium Bilirubin, total Albumin AST (SGOT) Alkaline Phosphatase Protein, total ALT (SGPT)	Electrolyte Panel 80051 Sodium Potassium Chloride Carbon Dioxide Basic Metabolic Panel 80048 Sodium Potassium Chloride Carbon Dioxide Glucose Creatinine BUN Calcium	Renal Function Panel 80069 Sodium Potassium Chloride Carbon Dioxide Glucose Creatinine BUN Calcium Albumin Phosphorus, inorganic (Phosphate)	Hepatitis Acute Panel 80074 Hep B surface antigen (HBsAg) Hep B core antibody (HBcAb), IgM Hep C antibody Hep A antibody, IgM Lipid Panel 80061 Cholesterol, total Triglycerides HDL cholesterol LDL cholesterol (calculated)	Liver Panel 80076 Albumin Bilirubin, total and direct ALT (SGPT) AST (SGOT) Alkaline Phosphatase Protein, total Obstetric Panel 80055 CBC Hep B Surface antigen (HbsAg) Antibody, Rubella RPR ABO/Rh type Antibody screen		
Bilirubin, total Albumin AST (SGOT) Alkaline Phosphatase Protein, total	Chloride Carbon Dioxide Glucose Creatinine BUN	Calcium Albumin Phosphorus, inorganic	Cholesterol, total Triglycerides HDL cholesterol	CBC Hep B Surface antigen (HbsAg) Antibody, Rubella RPR ABO/Rh type		

REFLEX/CONFIRMATORY TESTING NOTICE

It is the policy of Providence Alaska Medical Center laboratory to perform reflex or confirmatory test automatically on microbiological cultures (gram stain, bacterial identification and susceptibility, if warranted, unless otherwise requested), positive HIV (Western Blot), positive Hepatitis B Surface Antigen test, positive, reactive RPRs (FTA-Abs), CSF or Body Fluid Cell Count, Lipid Panel Triglyceride >400mg/dL (direct measure LDL), and CSF Cell Count, Malaria smear, CBC/Blood Count (Pathologist review). CBC will be ordered if not completed within 24 hours of flow cytometry request. Many of these tests are also available without confirmation, if desired. Transfusion Medicine will perform additional testing as needed to identify auto- and allo-antibodies, and/or to provide compatible blood products for transfusion. The subsequent testing is performed at additional charge. Medical necessity must apply to the reflex test also. Refer to Providence Alaska Medical Center laboratory's Testing Manual for details.

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	, ,						☐ FEMALE	
LAST: FIRST:				MI:		OTHER		
BIL	L: #: COMPI	NT BILL PLETE REQUIRED EAS BELOW	INSURANCE COMPLETE ALL AREAS	SUBSCRIBER (LAST, FIR	ST, MIDDLE)	DATE OF	BIRTH	
	GUARANTOR (LAST, FIRST, MIDDLE) (REQUIRED EXCEPT FO			ADDRESS (CITY, STATE,	ZIP)	I		
≥								
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3 MONDAY	CITY/STATE/ZIP CODE:			INSURANCE CO.				
NIN	PT. RELATIONSHIP:			CLAIMS ADDRESS (CITY, STATE, ZIP)				
FOLLOWING	HOME PHONE NO.: WORK PH	PHONE NO.:		INSURANCE PHONE	INSURANCE/MEMBER P	OLICY # GROUP #	ŧ	
윤	Date of Service (Collection):/_	/ Time	:	COPY To:	1	'		
井				ore: Right Left				
F	, ·	•	GCSF: Ye	•				
Ę	Ancillary Tests: CBC w/diff and slide re							
UNTIL	Microbiology (Use bone marrow culture collections)				 ogy I ab (907) 212-3025):	□ AFB □ Bouti	ne 🗆 Fungus	
13	DIAGNOSIS*	outer the or place in ele	THE CONTAINED.	Obtain the north thiorobiologic	/gy Lub (001) L1L 0020).		no 🗀 r unguo	
RESULTS		Cell Lymphoma C	86.5 □	CML C92.10 □ C	LL C91.10	L C91.00 □	AML C92.00	
ES	☐ MDS D46.9 ☐ Myeloproliferative		eloma/MG				A	
		Anemia D64.9	•	ocytopenia D69.6	☐ Other			
AR	*All diagnosis should be provided by the ordering p					rrent version of the	ICD-10-CM Book	
Z				o. Tot a complete listing of	10D-10 codes feler to a ce	arrent version or the	IOD-10-OW BOOK.	
Hodgkin Lymphoma C81.90 Anemia D64.9 Thrombocytopenia D69.6 Other *All diagnosis should be provided by the ordering physician or their authorized designee. For a complete listing of ICD-10 codes refer to a current version of the ICD-10-ID-ID-ID-ID-ID-ID-ID-ID-ID-ID-ID-ID-ID-								
PR	CYTOGENETICS (Na Heparin tube at room temp. 7-10 mL peripheral blood or 1-2 mL marrow)							
VE	☐ Routine Karyotype							
NOT HAVE	FISH *NHL = Non-Hodgkin Lymphoma				·			
5	CML B/T ALL MDS AML	☐ APL ☐ MIYE	eloma/MGUS	☐ Indolent B-NHL*	☐ Aggressive B-NH	L* Other		
		preferred, 72 hour st	ability. Or El	OTA 24 hour stability)				
WILL								
SS	MOLLOGIANI GIODILO (LDIA tabe at 100							
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ပ္ထ	☐ B-cell clonality ☐ T-cell clonality ☐ FLT3 mutation ☐ NPM1 ☐ Reflex if negative to CEBPA (check if reflex also approved)							
3	☐ Reflex testing JAK2 > CALR > MPL OR ☐ JAK2 ☐ Calreticulin ☐ MPL ☐ PML – RARA PCR ☐ Other							
ပ္ပ	Additional Test/Comments:							
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₽	Pertinent Clinical history:							
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WARNING: FRIDAY COLLECTION								
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	Ordering Provider (Print First and Last Name)	e)						
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La	b Use Only: Prior testing (flow/molecular) \square	res ⊔ No Lab_			Date			

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