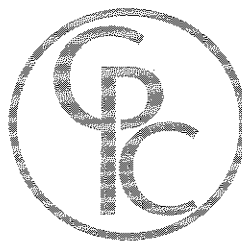


Consolidated Pathology Consultants

28100 N. Ashley Cr., #106
 Libertyville, Illinois 60048
 Phone (877) 631-PATH (7284)
 Fax (847) 996-1076



HEMATOPATHOLOGY REQUISITION

Patient Data				Billing Information (Continued)			
Name (Last, First)				Responsible Party (Last, First) Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other			
Patient I.D. or SSN		Office MR #		Address Apt. No.			
Date of Birth (Month, Day, Year)		<input type="checkbox"/> Male <input type="checkbox"/> Female		Date Collected		Time Collected <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	
Physician Signature (Required for Medicaid)		Physician Medicaid #		NPI #		Patient Phone No. ()	
Additional Reports to:				Medicare I.D. Number		Medicare I.D. Number (Incl. Suffix)	
				Primary Insurance Name and Plan		HMO <input type="checkbox"/> Y <input type="checkbox"/> N	
				Policy I.D. Number		Group No.	

Billing Information			
<input type="checkbox"/> Account <input type="checkbox"/> Medicare <input type="checkbox"/> Insurance <input type="checkbox"/> Patient			
MEDICARE PATIENTS: Please complete the Advanced Beneficiary Notice (ABN) and attach to the requisition when submitting a specimen			
Street		City State Zip	

ICD Diagnosis Codes (Enter All That Apply)			
①	②	③	④

Specimen Information	
<input type="checkbox"/> Abnormal CBC <input type="checkbox"/> Anemia <input type="checkbox"/> Thrombocytopenia <input type="checkbox"/> Polycythemia <input type="checkbox"/> Thrombocytosis <input type="checkbox"/> Leukopenia <input type="checkbox"/> Other <input type="checkbox"/> Leukocytosis	<input type="checkbox"/> Other
<input type="checkbox"/> Lymphoma/Lymphoproliferative Disorder <input type="checkbox"/> CLL <input type="checkbox"/> Mantle Cell Lymphoma <input type="checkbox"/> MALT Lymphoma <input type="checkbox"/> Hairy Cell Leukemia <input type="checkbox"/> Follicular Lymphoma <input type="checkbox"/> Other	<input type="checkbox"/> Acute Leukemia <input type="checkbox"/> AML <input type="checkbox"/> APL <input type="checkbox"/> ALL <input type="checkbox"/> Other
<input type="checkbox"/> Hodgkin Disease	<input type="checkbox"/> Myelodysplasia <input type="checkbox"/> RA <input type="checkbox"/> RAEB <input type="checkbox"/> RARS <input type="checkbox"/> CMMoL <input type="checkbox"/> Other
<input type="checkbox"/> Plasma Cell Dyscrasia <input type="checkbox"/> MM <input type="checkbox"/> MGUS <input type="checkbox"/> Smoldering Myeloma <input type="checkbox"/> Waldenstrom's	<input type="checkbox"/> Myeloproliferative Disorder <input type="checkbox"/> CML <input type="checkbox"/> ET <input type="checkbox"/> PV <input type="checkbox"/> MF
Collection Date: _____ Collection Time: _____ <input type="checkbox"/> Peripheral Blood <input type="checkbox"/> Other Tissue Source: _____ <input type="checkbox"/> BM Aspirate <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilateral <input type="checkbox"/> BM Core <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilateral	
Status/Purpose of Biopsy <input type="checkbox"/> New Dx <input type="checkbox"/> Relapse <input type="checkbox"/> Monitoring <input type="checkbox"/> Min. Res. Dis.	
Previous Therapy <input type="checkbox"/> Chemo <input type="checkbox"/> Rituxan <input type="checkbox"/> GMCSF <input type="checkbox"/> Gleevec <input type="checkbox"/> EPO <input type="checkbox"/> BMT <input type="checkbox"/> XRT <input type="checkbox"/> Other	

EVALUATION REQUESTED

Comprehensive Study — Includes morphologic evaluation plus immunophenotyping, special stains, cytogenetics, FISH and molecular studies as indicated.

Morphologic Evaluation		Cytogenetics		Flow Cytometry/Immunophenotyping	
<input type="checkbox"/> FISH <input type="checkbox"/> CLL <input type="checkbox"/> MDS <input type="checkbox"/> AML <input type="checkbox"/> MM-MGUS <input type="checkbox"/> NHL <input type="checkbox"/> 11q-/17p- <input type="checkbox"/> 5q-/5 <input type="checkbox"/> 5q-/5 <input type="checkbox"/> 1q+ <input type="checkbox"/> IgH/CCND1 <input type="checkbox"/> +12/13q- <input type="checkbox"/> 7q-/7 <input type="checkbox"/> 7q-/7 <input type="checkbox"/> +3 <input type="checkbox"/> t(11;14) <input type="checkbox"/> IgH/CCND1 <input type="checkbox"/> +8 <input type="checkbox"/> +8 <input type="checkbox"/> +5 <input type="checkbox"/> IgH/BCL-2 <input type="checkbox"/> t(11;14) <input type="checkbox"/> 20q- <input type="checkbox"/> AML1/ETO <input type="checkbox"/> +9 <input type="checkbox"/> t(14;18) <input type="checkbox"/> CML <input type="checkbox"/> MLL (11q23) <input type="checkbox"/> -13/13q- <input type="checkbox"/> IgH/MYC <input type="checkbox"/> BCR/ABL <input type="checkbox"/> inv(16) <input type="checkbox"/> IgH <input type="checkbox"/> t(8;14) <input type="checkbox"/> PML/RARA <input type="checkbox"/> 17p- (p53) <input type="checkbox"/> IgH <input type="checkbox"/> t(8;14) <input type="checkbox"/> MYC <input type="checkbox"/> BCL-6 <input type="checkbox"/> MALT1 <input type="checkbox"/> ALK		<input type="checkbox"/> Acute Leukemia/MDS <input type="checkbox"/> Lymphoma/CLL		<input type="checkbox"/> Molecular Genetics <input type="checkbox"/> BCR/ABL by RT-PCR (Quantitative) (CML) <input type="checkbox"/> B Cell Gene Rearrangement (B Cell Lymphoma) <input type="checkbox"/> T Cell Gene Rearrangement (T Cell Lymphoma) <input type="checkbox"/> JAK2 Mutation (MPD) <input type="checkbox"/> PML/RARA (APL) <input type="checkbox"/> BCL2 /IgGH (Follicular Lymphoma) <input type="checkbox"/> BCL1/IgGH (Mantle Cell Lymphoma)	