Knowledge from people who care

Sabaneta Industrial Park A-234 Ponce, P.R. 00716
Tel. (787) 841-8645 Fax. (787) 843-3464 / Lic. 809B/1155

NEXT VISIT TO PHYSICIAN: ___/___/___ (mm/dd/yy)

LAB. NUMBER: ______

HEMATOLOGY-ONCOLOGY REQUISITION

PATIENT INFORMATION

Patient Name: ______ Age: ______

Gender: ◯F ◯M DOB: ___/___/___ (mm/dd/yy) SS No.: XXX-XX-______ Phone No: (___) ___-______

Postal Address: ______

Med Record No.: ______

BILLING INFORMATION (Please provide copy of insurance card)

Bill to: ◯Client ◯Insurance ◯Patient ICD 9/10 CODE: ______

Health Insurance: ______ Insurance Contract No.: ______

Group No.: ______

PATIENT'S CLINICAL HISTORY (Please Include CBC and other pathology reports)

ICD-9/10 Codes or Diagnosis: ______

Clinical History: ______

Previous Therapy: ______ Previous Therapy: ______

COMPREHENSIVE PANEL

- ◯ Bone Marrow Evaluation
- ◯ Peripheral Blood Evaluation
- ◯ Fresh Tissue Evaluation

MORPHOLOGY

- ◯ Bone Marrow Morphology
- ◯ Peripheral Blood Morphology
- ◯ Solid Tissue Morphology

CYTOGENETICS

- ◯ Reflex to FISH as medically necessary
- ◯ Chromosome analysis only
- ◯ Chromosome analysis and FISH

FLOW CYTOMETRY

- ◯ Non-Hodgkin's Lymphoma
- ◯ Acute Lymphoblastic Leukemia/Lymphoma
- ◯ Acute Myeloid Leukemia
- ◯ Myeloproliferative Disorder
- ◯ CLL Diagnostic/Prognostic Profile
- ◯ Paroxysmal Nocturnal Hemoglobinuria
- ◯ CLL Monitoring/Minimal Residual Disease
- ◯ Plasma Cell Myeloma
- ◯ Hairy Cell Myeloma
- ◯ Sézary Syndrome
- ◯ Mast Cell Disease
- ◯ Other: ______

FISH ANALYSIS

- ◯ Reflex as medically necessary
- ◯ ALL Panel
- ◯ CLL Panel
- ◯ Myeloma Panel
- ◯ CCND1 (Mantle Cell Lymphoma)
- ◯ Follicular Lymphoma t (14; 18) (Bcl-2)
- ◯ Acute Promyelocytic Leukemia t (15; 17) (PML-RARA)
- ◯ Myeloproliferative Panel
- ◯ MDS Panel
- ◯ BCR / ABL
- ◯ MLL (11q23)
- ◯ Burkitt's Lymphoma (c-myc)
- ◯ Other (specify): ______

ORDERING PHYSICIAN

Physician Name: ______

Phone No: ______

Address: ______

Physician Signature: ______

SPECIMEN INFORMATION

Collection Date: ___/___/___ (mm/dd/yy)

Collection Time: ___:___ AM PM

SPECIMEN TYPE OR SOURCE:

- ◯ Bone Marrow
- ◯ Peripheral Blood
- ◯ Fresh Tissue
- ◯ Lymph Node
- ◯ Formalin Fixed Tissue
- ◯ FNA
- ◯ CSF
- ◯ Pleural Fluid
- ◯ Other Fixative (specify): ______

STATUS:

- ◯ New Diagnosis
- ◯ Minimal Residual Disease
- ◯ Follow-up ◯ Relapse

THERAPY:

- ◯ Chemotherapy
- ◯ Radiotherapy
- ◯ Bone Marrow Transplant

MOLECULAR TESTS

- ◯ Reflex as medically necessary
- ◯ JAK2 (MPD/MPN)
- ◯ BCR – ABL 1 t (9:22)
- ◯ MPL W515L/K Mutation (MPD/MPN)
- ◯ T-Cell Clonality
- ◯ B-Cell Clonality
- ◯ IgVH Hypermutation Analysis (CLL)
- ◯ FLT3/NPM1 (AML)
- ◯ Ckit (AML)
- ◯ PML/RARA (APL)
- ◯ CEBPA (AML)
- ◯ Other (specify): ______

CONSULTATION

- ◯ Hematopathology Consultation Report
- ◯ Second Opinion Consultation

Yo autorizo a mi médico a proveer información a Southern Pathology Services para propósitos de facturación a mi plan médico. De mi plan médico no cubrir la(s) prueba(s) de patología, me hago responsable del costo ya sea del deducible o el costo total de la(s) prueba(s).

I authorize my physician to provide information to Southern Pathology Services for billing purposes to my Medical Insurance Plan. I will be responsible for the deductible or total cost of test(s) if my medical insurance determines it is a non-covered service.

Patient Signature: ______ **Date:** ______ (mm/dd/yy)

This SLIP REQUEST is confidential and contains privileged information. Inappropriate disclosure is prohibited by law.
If by accident you receive this request, please contact us immediately at 787-841-8645