McLaren MEDICAL LABORATORY

Clinical Laboratory Requisition

Phone: 855-769-7030 Fax: 810-424-2504

PATIENT AND BILLING INFORMATION *(Please attach a copy of Drivers License and Insurance Card, both sides)*

Pt Last Name	First	MI	Date Collected - -	Time Collected ❍ AM ❍ PM :	Specimen is: ❍ Random ❍ Fasting

Birthdate - -	Gender ❍ M ❍ F	Patient SS# (Last 4 Digits Only) XXX-XX-	Pt. Telephone #	FIN

Pt Address	Ordering Provider (Full Name) **PRINT ONLY**:
City, State, Zip	**First Name**:_____
Name of Guarantor / Relation / Birthdate - -	**Last Name**:_____
Address / City, State, Zip	**NPI**:_____
Patient is: ❍ Subscriber ❍ Spouse ❍ Dependent — Bill To: ❍ Insurance* ❍ Patient (Self-Pay) ❍ Client ❍ Client (Technical Only)	
Subscriber Last Name / First / MI	**[ ] Copy To (physician full name, office ph # & office fax # below)**
Policy # / Group #	Ordering Provider Signature:
DIAGNOSIS CODE(S)/REASON FOR TESTING (Required)	

CLINICAL INFORMATION

Patient Status: ❍ New Diagnosis ❍ Remission ❍ Monitoring ❍ Relapse ❍ Hx of Therapy (Specify)_____

DISEASE STATE UNDER CONSIDERATION

MYELOID NEOPLASMS

❍ Anemia/leukopenia/thrombocytopenia w/Negative Clinical Workup
❍ AML (APL)
❍ AML (Non-APL)
❍ CML
❍ CMML
❍ Essential Thrombocytopenia
❍ MDS
❍ MDS/MPN
❍ MPN
❍ Polycythemia
❍ Primary Myelofibrosis
❍ Other_____

LYMPHOPROLIFERATIVE NEOPLASMS/PLASMA CELL DYSCRASIAS

❍ B-ALL
❍ Burkitt Lymphoma
❍ CLL/SLL
❍ Diffuse Large B-Cell ymphoma
❍ Follicular Lymphoma
❍ Hairy Cell Leukemia
❍ Hodgkin's Lymphoma
❍ Mantle Cell Lymphoma
❍ Marginal Zone Lymphoma/MALT
❍ MGUS
❍ Plasma Cell Myeloma
❍ T-ALL
❍ Waldenström's Macroglobulinemia
❍ Other_____

SPECIMEN TYPE *(Store and Ship at 2-8 ° - DO NOT FREEZE, unless otherwise indicated)*

❍ Peripheral Blood (~5 mL in EDTA)** ☐ Tube ☐ Smear

*****ALL other Specimen Types MUST BE sent out to Genpath*****

Examples :

* Bone Marrow
* Lymph Nodes
* CSF
* Pleural Fluid
* FNA
* Other Tissues
* Other Fluids

*** Note: Store & Ship at Room Temperature. Include recent CBCw/Diff & Retic printout*

IMMUNOPHENOTYPING OF PERIPHERAL BLOOD/BONE MARROW/FNA/LYMPH NODE/TISSUE

PANEL	MARKERS
❍ Acute Lymphocytic Leukemia or Myelocytic Leukemia	CD1a, 2, 3, 4, 5, 7, 8, 10, 11b, 11c, 13, 14, 15, 19, 33, 34, 41, 45, 61, 117, 235a, HLA-Dr, Kappa & Lambda
❍ B-Cell, Mature Leukemia/Lymphoma *(Do not order with B-Cell Clonality)*	CD3, 5, 10, 11c, 19, 20, 23, 34, 38, 45, 103, FMC7, Kappa & Lambda
❍ T-Cell, Mature Leukemia/Lymphoma	CD2, 3, 4, 5, 7, 8, 22, 25, 45 & 56
❍ Plasma Cell/Myleoma	CD19, 56, 45, 38, 117, 138, cyto. Kappa & cyto. Lambda
❍ Screen Tube	CD3, 5, 10, 19, 23, 33, 34, 56, FMC7, Kappa & Lambda

CEREBROSPINAL FLUID (CSF)

PANEL	MARKERS
❍ B-Cell Clonality	CD3, 5, 10, 19, 20, 23, 45, Kappa & Lambda

BODY FLUIDS

PANEL	MARKERS
❍ Fluid T-Cell Subsets	CD2, 3, 4, 7, 8, 45 & 56

ADDITIONAL TESTING/COMMENTS

❍ Hold Flow Sample Pending Pathologist Review

Name:_____ DOB:_____Spc:_____ Name:_____ DOB:_____Spc:_____ Name:_____ DOB:_____Spc:_____ Name:_____ DOB:_____Spc:_____