

HEMATOLOGY/ONCOLOGY REQUISITION FORM

PATIENT INFORMATION					
Last Name	First Name	MI	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	DOB / /	SSN - -
Address	City	State	Zip	Phone () -	Patient ID/MRN

ORDERING PHYSICIAN INFORMATION	Copy Report to Additional Physician	BILLING INFORMATION
Physician and Facility (Name, address, phone and fax)	Physician Name	Bill to <input type="checkbox"/> Insurance (Please attach copy of insurance card) <input type="checkbox"/> Medicare <input type="checkbox"/> Hospital/Direct Bill <input type="checkbox"/> Patient Self-Pay
	Phone () -	Patient Status <input type="checkbox"/> Hospital Inpatient (>24 hour stay) Discharge Date / / <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Non-Hospital Patient
	Fax () -	Hospital Name


CLINICAL INFORMATION - Copy of CBC and patient's history is required. Refer to the back of the requisition for common ICD-10 codes.

Signs/Symptoms (Include as many as applicable)

CLINICAL INDICATION	CLINICAL STATUS	ICD-10 CODES
<input type="checkbox"/> ALL <input type="checkbox"/> AML <input type="checkbox"/> CLL/SLL <input type="checkbox"/> CML <input type="checkbox"/> Other _____	<input type="checkbox"/> Hodgkin Lymphoma <input type="checkbox"/> MDS/MPD <input type="checkbox"/> Multiple Myeloma/MGUS <input type="checkbox"/> NHL/LPD	<input type="checkbox"/> New Diagnosis <input type="checkbox"/> Staging <input type="checkbox"/> Monitoring
	<input type="checkbox"/> MRD <input type="checkbox"/> Under Therapy <input type="checkbox"/> Post Therapy	1. 2. 3. 4. 5. 6.

SPECIMEN INFORMATION			Collection Date	Collection Time
<input type="checkbox"/> Bone Marrow	<input type="checkbox"/> Peripheral Blood	<input type="checkbox"/> Other: _____	/ /	<input type="checkbox"/> AM <input type="checkbox"/> PM

TEST(S) REQUESTED

 **Comprehensive Omnia™ Assessment**

Includes: Clinical history review and morphologic assessment. Medically necessary tests will be ordered by an expert pathologist from the Yale University School of Medicine. Tests may include IHC, flow cytometry, cytogenetics, FISH and/or molecular testing. A summary with correlation of all testing technologies will be incorporated into one final diagnostic Omnia™ report.

ADDITIONAL INSTRUCTIONS - Please specify additional tests, notes, requests, etc. Refer to the reverse side for our complete test menu.

<input type="checkbox"/> I would like the hematopathologist to call me to discuss this case.	Preferred Phone Number: () -	Patient's next scheduled visit: (this will assist us in managing the diagnostic timeline to ensure all results are available for the patient's next visit.)	Date / /
--	-------------------------------	--	-------------

Authorized Signature	Date / /
-----------------------------	--------------------

TEST MENU		
Flow Cytometry <input type="checkbox"/> ALL/AML <input type="checkbox"/> APL <input type="checkbox"/> CLL/SLL <input type="checkbox"/> CML <input type="checkbox"/> Follicular Lymphoma <input type="checkbox"/> HCL <input type="checkbox"/> LGL <input type="checkbox"/> MDS/MPD <input type="checkbox"/> Multiple Myeloma/MGUS <input type="checkbox"/> NHL /LPD <input type="checkbox"/> PNH <input type="checkbox"/> Other _____	Microscopic / Morphology <input type="checkbox"/> Microscopic/Morphologic Analysis Cytogenetics <input type="checkbox"/> Chromosome Analysis Fluorescent In-Situ Hybridization (FISH) <input type="checkbox"/> ALL <input type="checkbox"/> AML <input type="checkbox"/> APL <input type="checkbox"/> CLL/SLL <input type="checkbox"/> CML <input type="checkbox"/> DLBCL <input type="checkbox"/> Follicular Lymphoma <input type="checkbox"/> Other _____ <input type="checkbox"/> LPL – Waldenström <input type="checkbox"/> Mantle Cell Lymphoma <input type="checkbox"/> Marginal Zone Lymphoma <input type="checkbox"/> MDS/MPD <input type="checkbox"/> Multiple Myeloma/MGUS <input type="checkbox"/> P. vera	Molecular (PCR) <input type="checkbox"/> B-Cell Gene Rearrangement <input type="checkbox"/> BCR/ABL Qualitative (p210/p190 Detection) <input type="checkbox"/> BCR/ABL Quantitative (p210 Detection/Monitoring) <input type="checkbox"/> CALR <input type="checkbox"/> FLT3-IDT/Mutation <input type="checkbox"/> IgHV <input type="checkbox"/> JAK2 V617F If JAK2 V617F is negative, reflex <input type="checkbox"/> JAK2 Exon 12 <input type="checkbox"/> CALR <input type="checkbox"/> MPL <input type="checkbox"/> Kit Mutation <input type="checkbox"/> MDS (JAK2 V617F, JAK2 Exon 12 & MPL) <input type="checkbox"/> MPD (JAK2 V617F, JAK2 Exon 12, MPL, BCR/ABL Qualitative & CALR) <input type="checkbox"/> MPL <input type="checkbox"/> NMP1 <input type="checkbox"/> PML-RARA Quantitative <input type="checkbox"/> T-Cell Gene Rearrangement

Specimen Requirements and TAT

Test Type	Specimen Type	Preservative	Instructions	Volume	Temperature	Stability	TAT
Morphology & Special Stains	Core Biopsy	Formalin	Saturated core complete with fixative	N/A	Room Temperature	72 hrs	48 hrs
	Blood Clot	Formalin	Saturated core complete with fixative	N/A	Room Temperature	72 hrs	48 hrs
	Bone Marrow Aspirate Slides	N/A	Unstained, unfixed	5 Slides	Room Temperature	N/A	48 hrs
IHC & CISH	Core Biopsy	Formalin	Saturated core complete with fixative	N/A	Room Temperature	72 hrs	3 days
	Blood Clot	Formalin	Saturated core complete with fixative	N/A	Room Temperature	72 hrs	3 days
	FFPE Tissue	N/A	Formalin fixed paraffin embedded tissue	N/A	Room Temperature	N/A	48 hrs
Flow Cytometry	Bone Marrow & Peripheral Blood	Green Top or Lavender Top Tube	N/A	2-3 mL	Room Temperature	48 hrs	24 hrs
	Fluid	N/A	Fluid in sterile container with no preservative	2 mL	Refrigerate - Do Not Freeze	48 hrs	24 hrs
	Fresh Tumor	RPMI	1-5cm ³ marble-sized piece of fresh tumor	1-5cm ³	Refrigerate - Do Not Freeze	48 hrs	24 hrs
Chromosome Analysis	Bone Marrow	Green Top Tube	N/A	2 mL	Room Temperature	48 hrs	Culture + 48 hrs
Fluorescent In-Situ Hybridization (FISH)	Bone Marrow & Peripheral Blood	Green Top or Lavender Top Tube	Saturated core complete with fixative	2-3 mL	Room Temperature	48 hrs	48 hrs
	Fluid	N/A	Fluid in sterile container with no preservative	2 mL	Refrigerate - Do Not Freeze	48 hrs	48 hrs
	Fresh Tumor	RPMI	1-5cm ³ marble-sized piece of fresh tumor	1-5cm ³	Refrigerate - Do Not Freeze	48 hrs	48 hrs
Molecular (PCR)	Bone Marrow & Peripheral Blood	Green Top or Lavender Top Tube	N/A	2 mL	Room Temperature	72 hrs	7 days
	Fluid	N/A	Fluid in sterile container with no preservative	2 mL	Refrigerate - Do Not Freeze	48 hrs	7 days
	Fresh Tumor	RPMI	1-5cm ³ marble-sized piece of fresh tumor	1-5cm ³	Refrigerate - Do Not Freeze	48 hrs	7 days
Additional Notes	Specimens should be sent within 24 hours of draw. Include CBC, clinical history, and prior test results if available. Clearly label each tube, slide and container with patient initials. Allow slides to air dry completely before placing them in slide holders provided. Please store all RPMI in refrigerator prior to use. DO NOT use RPMI if it appears cloudy, yellow, or beyond expiration date. For questions or assistance please call customer service at 203.787.1717.						
Specimen Shipping	Ship at room temperature. In warm weather place the specimen kit into a climate control bag* and include a cool pack. DO NOT allow cool pack to be in direct contact with sample. DO NOT EXPOSE PATIENT NAME OR OTHER IDENTIFYING INFORMATION ON THE SHIPPER. HIPAA regulations prohibit disclosure of confidential patient information. Use our iOS App: Precipio or call Customer Service at 203.787.1717 to schedule a specimen pickup. *Please contact your Precipio Diagnostics sales manager to obtain more information about our climate control bags.						
Reporting of Results	A final report will be available to the requesting physician on iLab Connect™ at www.precipiodx.com and our iOS App: Precipio.						
Common ICD-10 Codes	C81.90 Hodgkin Lymphoma, unspecified C85.80 Non-Hodgkin Lymphoma, unspecified C90.00 Multiple Myeloma C90.10 Plasma Cell Leukemia C91.00 Acute Lymphoid Leukemia (ALL) C91.10 Chronic Lymphocytic Leukemia (CLL) of B-cell type C92.00 Acute Myeloblastic Leukemia (AML) C92.10 Chronic Myeloid Leukemia (CML), BCR/ABL positive C92.40 Acute Promyelocytic Leukemia		C92.50 Acute Myelomonocytic Leukemia C92.Z0 Other Myeloid Leukemia C95.00 Acute Leukemia, unspecified cell type C95.10 Chronic Leukemia, unspecified cell type D47.3 Essential Thrombocythemia D46.9 Myelodysplastic Syndrome, unspecified D47.2 Monoclonal Gammopathy D61.810 Antineoplastic chemotherapy induced pancytopenia D61.811 Other drug-induced pancytopenia		D61.818 Other pancytopenia D64.9 Anemia, unspecified D69.6 Thrombocytopenia, unspecified D70.9 Neutropenia, unspecified D75.819 Leukopenia, unspecified D72.829 Leukocytosis J91.8 Pleural effusion in other conditions classified elsewhere R22.0 Localized swelling of mass in head R22.1 Localized swelling of mass in neck		