RAPID AML COMPLETE™ TEST REQUISITION FORM

PATIENT INFORMATION

Last Name	First Name	MI	Gender	DOB	Patient ID/MRN/SSN
			☐ Male ☐ Female		

Address	City	State	ZIP	Phone
				( ) –

PHYSICIAN INFORMATION

Physician and Ordering Facility (Name, Address, Phone and Fax)

Copy report to additional Physician

Physician Name

Phone ( ) –

Fax ( ) –

BILLING

This service is available as client bill only.

CLINICAL STATUS

☐ New Diagnosis ☐ Monitoring ☐ Under Therapy

☐ Post Therapy ☐ Staging ☐ MRD

ICD-10 CODES

1. 2.

3. 4.

☐ Bone Marrow Aspirate X_____ (1 tube min. 1 ml)

☐ Peripheral Blood X _____ (2 tubes min. 2 ml each)

* EDTA tubes only.

Collection Date: ___ / ___ / ___

Time of Collection: ____ : ____ ☐ AM ☐ PM

TEST(S) REQUESTED

Rapid AML Complete™

Service includes:
Step 1 – Rapid Bloodhound AML panel (IDH1, IDH2, KIT, FLT3 (IDT & TKD), NPM1, CEBPA)
Step 2 – NGS 58-Gene Myeloid panel

COMMENTS

(Please specify additional tests, notes, requests, etc.)

Physician Signature: _____ **Date:** ___ / ___ / ___