



8700 W Flagler Street  
 Miami, FL 33174  
 Ph: (305) 267-7979  
 Fx: (786) 513-0175

# HEMATOLOGY / ONCOLOGY REQUISITION



EIN: 20-4506043 | CLIA: 10D1055514

## Patient Information

Last	First	MI
DOB	SSN	<input type="checkbox"/> F <input type="checkbox"/> M
Address		
City	State	ZIP
		Phone

## Physician Information    Institution:

Submitted by:  Dr. \_\_\_\_\_

Address: \_\_\_\_\_

Reporting Method  
 Online (Report Viewer)  
 Fax

Copy to: \_\_\_\_\_ Fax \_\_\_\_\_

## Billing

<input type="checkbox"/> Insurance	<input type="checkbox"/> Hospital non-patient
<input type="checkbox"/> Hospital in-patient	<input type="checkbox"/> Client Bill
Insurance Information (complete this section and/or use check boxes below)	
ICD-10 CODE:	
Name of Carrier	Phone #
Carrier Address	
Policy #	Group/Plan #
Name of Insured (if not same as patient)	
DOB of Insured	Relationship to Patient
<input type="checkbox"/> SEE ATTACHED	<input type="checkbox"/> Secondary insurance exists. Please include a second sheet.

## Clinical Notes (please provide copy of CBC):


## Bone Marrow Checklist:

<input type="checkbox"/> CBC	<b>Bone Marrow Aspirate for Ancillary Studies</b>
<input type="checkbox"/> Blood smears	<input type="checkbox"/> Flow (purple top tube)
<input type="checkbox"/> Bone Marrow aspirate smears	<input type="checkbox"/> Cytogenetics (green top tube)
<input type="checkbox"/> Touch Imprints	<input type="checkbox"/> Molecular (purple top tube)
<input type="checkbox"/> Bone Marrow core (≥ 1.5 cm)	
<input type="checkbox"/> Bone Marrow clot	

## Specimen Information

Body Site: \_\_\_\_\_

Collection Date: \_\_\_\_\_

<input type="checkbox"/> Blood	<input type="checkbox"/> Green top (Qty____)	<input type="checkbox"/> Purple top (Qty____)	<input type="checkbox"/> Smears (Qty____)	<input type="checkbox"/> Biopsy	<input type="checkbox"/> Clot
<input type="checkbox"/> Bone Marrow	<input type="checkbox"/> Green top (Qty____)	<input type="checkbox"/> Purple top (Qty____)	<input type="checkbox"/> Smears (Qty____)	<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Lymph node/other tissues/fluids	<input type="checkbox"/> RPMI	<input type="checkbox"/> Tissue Block			

## Test Menu

**Comprehensive Evaluation With Summary Report:** (Morphology with stains, Flow Cytometry, Cytogenetics, FISH, Molecular as deemed necessary by a Vitro pathologist.)

**Morphology:** (with stains as deemed necessary by a Vitro pathologist) with select ancillary studies (please select below tests desired.)

**Morphology Only** (specimen processed at Vitro, including stains deemed necessary by a Vitro pathologist)

**Morphology Only On Referred Material** (specimen processed by outside lab, stains performed at Vitro as deemed necessary by Vitro pathologist.)

**Consultation/Second Opinion** (please include all pertinent slides and pathology reports; stains performed at Vitro as deemed necessary by a Vitro pathologist.)

<b>Flow Cytometry</b>	<input type="checkbox"/> Comprehensive Analysis	<input type="checkbox"/> PNH panel	<input type="checkbox"/> T-cell subset	<input type="checkbox"/> Other
<b>Cytogenetics</b>	<input type="checkbox"/> Cytogenetics (reflex to FISH if necessary)			
<b>FISH Studies</b>				
<input type="checkbox"/> BCR/ABL	<input type="checkbox"/> MDS panel	<input type="checkbox"/> Myeloma panel	<input type="checkbox"/> CLL panel	<input type="checkbox"/> Double hit lymphoma
<b>Molecular Studies</b>				
<input type="checkbox"/> BCR/ABL	<input type="checkbox"/> JAK2	<input type="checkbox"/> MPN panel	<input type="checkbox"/> B-cell clonality	<input type="checkbox"/> T-cell clonality
<b>NGS (select panel below)</b>				
<input type="checkbox"/> Solid Tumor Profile Plus (DNA + RNA)	<input type="checkbox"/> Solid Tumor Profile (DNA Only)	<input type="checkbox"/> Solid Tumor Liquid Trace	<input type="checkbox"/> Hematology Profile Plus (DNA + RNA)	<input type="checkbox"/> Hematology Profile (DNA Only)
		<input type="checkbox"/> Hematology Liquid Trace		