Hematopathology Requisition
FLOW CYTOMETRY / FISH / BONE MARROW

Dahl-Chase Pathology Associates
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(207) 941-8200 / 1-800-660-1626

DAHL-CHASE PATHOLOGY ASSOCIATES

Name	Name	Name
DOB or MRN	DOB or MRN	DOB or MRN
Source	Source	Source

PLEASE PRINT
COMPLETE ALL PATIENT INFORMATION OR ATTACH DEMOGRAPHIC SHEET AND/OR COPY OF INSURANCE CARD(S) (BOTH SIDES)

PATIENT

Patient Name (Last, First, MI)		
Date of Birth	**Sex** ☐ M ☐ F	Telephone
Social Security Number		Medical Record Number
Mailing Address		
City, State, Zip		

CLINICIAN

Provider Performing Procedure (Last, First)	
Clinician Office/Clinic/Hospital Name	
Collection Date & Time	Requisition completed by

INSURANCE

Primary Insurance Name	
Primary Insurance Policy ID	Group Number
Primary Medical Claims Address, City, State, Zip	
Secondary Insurance Name	
Secondary Insurance Policy ID	Group Number
Secondary Medical Claims Address, City, State, Zip	
Copy to Clinician Name (Last, First, & Office Location)	
☐ Correlation with previous or concurrent case: _____	

CASE PRIORITY:
☐ ROUTINE
☐ Next Business Day Rapid (will call office)
☐ Next Day Rapid (will call provider on weekends and holidays)
Provider contact # required _____

LOCATION OF COLLECTION:
☐ Day Surgery ☐ Inpatient Floor ☐ Physician office patient
☐ Emergency Room ☐ OR ☐ Radiology/Ultrasound/CT
☐ Endoscopy ☐ Outpatient/Lab ☐ _____

SPECIMEN TYPE:

❑ Peripheral Blood ❑ Lymph Node (specify source) _____ ❑ Other (specify source) _____
❑ Bone Marrow ❑ CSF ❑ Mediastinal Mass ❑ Body Fluids _____

PERTINENT CLINICAL INFORMATION:

Diagnosis / History: _____ Background: ❑ New Diagnosis ❑ Staging ❑ Follow up ❑ Patient on protocol

Check if any are present:
❑ Blasts in peripheral blood ❑ Lymphocytosis ❑ Monoclonal gammopathy
❑ Pancytopenia / Cytopenia ❑ Eosinophilia ❑ Monocytosis / Leukocytosis
❑ Lymphadenopathy ❑ Mass / nodule

Evaluate for:
❑ Lymphoma ❑ Leukemia ❑ MGUS / Myeloma
❑ MDS ❑ Myeloproliferative disorder ❑ Other _____

☐ COMPREHENSIVE HEMATOPATHOLOGY CONSULTATION

*Based upon specimen adequacy, clinical indication and initial results, hematopathologists may add, delete or modify orders if needed to obtain a diagnosis

☐ FLOW CYTOMETRY
☐ Reflex to FISH if indicated

Call 941-8282 prior to sending these specimens and include CBC for blood and bone marrows.

❑ Leukemia/lymphoma evaluation
❑ Acquired Immunodeficiency (CD4/8)
❑ Lymphocyte subsets (CD3/4/8/19/56)
❑ Lyme Disease panel (CD3/8/57)
❑ PNH Panel (FLAER/24/14/15/64/45)
❑ Fetal Hgb
❑ Other _____

☐ BONE MARROW SPECIMENS

Note: A recent CBC and peripheral smear should accompany this request.

Location: ❑ Rt. Iliac ❑ Lt. Iliac
❑ Other _____
❑ Aspirate Smear
Crush Slides _____
Push Slides _____
❑ Core Biopsy
Touch Prep _____
❑ Clot
Bone Marrow Obtained by _____

☐ CHROMOSOME ANALYSIS / CYTOGENTICS

ADDITIONAL TESTING

Molecular Studies
❑ NGS testing per NCCN guideline (AML, MDS, CLL, MM, etc.)
❑ PCR _____ (BCR/ABL (9;22), PML-RARA (15;17), JAK2, etc.)
❑ Gene Rearrangements (T-Cell, B-Cell, IGH, etc)
❑ Other _____ (for example, CEBPA, IDH1/2, KIT, NPM1, TP53, FLT-3 TKD, FLT3 ITD, MYD88, etc.)

FISH PANELS AND PROBES

❑ **Hematopathologist to select FISH panel as needed for diagnosis**
❑ **FISH Follow-up - FISH Panel will be selected based on previous abnormal**
❑ **Individual Probes:** _____

❑ **MM - Multiple myeloma panel**
❑ Only run if >5% plasma cells
❑ **AML - Acute myeloid leukemia panel**
❑ Only run if >10% blasts
❑ **MDS - Myelodysplastic syndrome panel**
❑ **APL - t(15;17) only**
❑ **ALL - Acute lymphoblastic leukemia panel**
❑ **CLL - Chronic lymphocytic leukemia panel**
❑ **CML - BCR/ABL t(9;22) only**
❑ **Chronic Eosinophilia panel**

Non-Hodgkin Lymphoma (NHL)
❑ **High grade lymphoma panel**
❑ **Follicular lymphoma - t(14;18)**
❑ **Mantle cell lymphoma - t(11;14)**
❑ **MALT lymphoma - MALT1**

For a list of probes included in a panel, please call 941-8228 or 941-8207

NOTES:

For detailed collection instructions, please refer to the Directory of Services on www.dahlchase.com

(10/4/21)

SPECIMEN REQUIREMENTS

Specimen Type	Cytogenetics / FISH	Flow Cytometry	Morphology	Molecular ★	Storage & Transport
Bone Marrow Aspirate ☆	1-2ml (min 0.5ml) marrow in white label black-capped tube. 0.5cc marrow in pink label black-capped tube. Invert several times.	Green Top (Sodium Heparin) 1 mL minimum 2-3 mL preferred	Direct push smears, Particle crush smears, Clot in B Plus	Purple Top (EDTA) 1 mL minimum 2-3 mL preferred (Store Refrigerated)	Ambient Temperature
Peripheral Blood	Green Top (Sodium Heparin) preferred	Purple Top (EDTA) or Green Top (Sodium Heparin) 2-5 mL	Purple Top (EDTA) 2-5 mL	Purple Top (EDTA) 2-5 mL (Store Refrigerated)	Ambient Temperature
Bone Marrow Biopsy ☆		1 cm Core if Dry Tap ✪	1.5 cm minimum Core (length) in B+ Fixative Touch preps of core if no aspirate or a poor aspirate is obtained	N/A	Ambient Temperature
Surgical Biopsy	RPMI Flow Cytometry Media	RPMI Flow Cytometry Media	N/A	N/A	Store Refrigerated Ship Ambient
CSF	N/A	RPMI Flow Cytometry Media	N/A	N/A	Store Refrigerated Ship Ambient
Body Fluid	N/A	Fresh Fluid	N/A	N/A	Store Refrigerated Ship Ambient

☆ **Required: Copy of CBC Results and Smear or Purple Top (EDTA)**

★ **Molecular needs to be stored refrigerated**

✪ **Please Place in RPMI**

PLEASE CALL 941-8282 FOR SUPPLIES AND NOTIFY US YOU ARE SENDING A SPECIMEN