Indiana University Health

IU Health System Pathology Laboratories
350 W. 11th Street, Room 5013
Indianapolis, IN 46202-4108
317.491.6000 or 800.433.0740
Fax: 317.491.6001

1) Patient Legal Name (Last, First MI)		DOB	2) ( ) STAT	Date/Time of Collection
Patient Social Security #	Race	MR#/Alternate Pt ID		Phone Results To:
Patient Address		Phone		Fax Results To:
City, State, Zip		M F	4) **BILL PATIENT/INSURANCE COMPANY** ATTACH A COPY OF FACE SHEET AND INSURANCE CARD - ALL required (highlighted) fields must be complete to bill patient's insurance company. Specimen will be registered as patient self-pay and bill will be the responsibility of the patient if required information is not provided.	
3) Physicians Signature	Order Date	Print Physicians Name (F,MI,L)		

Client (Clinic/Physician) Information	Group Physicians	Primary Insurance
		Company Name:
		IU/Policy# Group #/Name:
		Relationship to Patient:

Notice: Medicare will only pay for tests that meet the Medicare definition of "Medical Necessity". Medicare may deny payment for a test that the physician believes is appropriate, such as a screening test. If a test is being ordered as a screen, be certain the patient has signed the Advanced Beneficiary Notice (ABN) located on back of this requisition.	5) ICD Diagnosis Codes (Enter ALL that apply)		1	2	3
	4	5	6	7	8

Bone Marrow Pathology Requisition

Specimen Type

❒ BM Biopsy* _____*CM* ❒ BM Clot* **In 10% buffered formalin*

❒ BM Aspirate No. tubes *Dark green sodium heparin* ___ *EDTA* ___

❒ BM Aspirate Slides No. sent ___ **Site:** ❒ LPIC ❒ RPIC ❒ Sternum

❒ Peripheral Blood/Smears *(Submit results of CBC/Diff performed within 24 hours; send peripheral smear with all bone marrows)*

Clinical Information

❒ **INITIAL** ❒ **STAGING** ❒ **FOLLOW-UP** ❒ **POST TRANSPLANT**

❒ Anemia ❒ Leukopenia/Neutropenia ❒ Thrombocytopenia ❒ Myelodysplastic s.

❒ Leukemia, specify_____ ❒ Lymphoma, specify_____

❒ Plasma Cell Neoplasm, specify_____

❒ Myeloproliferative Neoplasm, specify_____

❒ Other, specify_____

Additional Studies

❒ **Chromosome Analysis (Karyotype)** *(Dark green sodium heparin tube. Performed at IU Cytogenetics Lab)*

❒ **Fluorescence *In-Situ* Hybridization (FISH)** *(Dark green sodium heparin tube. Performed at IU Cytogenetics Lab)*

❒ ALL Panel ❒ AML Panel ❒CLL Panel ❒ Lymphoma Panel ❒ MDS Panel ❒MPN Panel ❒ Plasma Cell Myeloma Panel

❒ t (9:22) BCR/ABL1 ❒ MLL ❒ TP53 ❒-5/del(5q) ❒ del(7q) ❒+8 ❒ del(20q) ❒PDGFRA ❒PDGFRB

❒ t (15:17) PML/RARA ***Stat?*** ❒***Yes*** ❒***No***

❒ Other or individual probes, specify_____ Call IUCL for information regarding additional available probes, 317-278-6528.

❒ **Cytochemical Stains** *(Unstained aspirate smears. Performed at IUHPL – Special Hematology)* ○ Iron Stain ○ BTE ○ MPX

❒ **Flow Cytometry** *(Dark green sodium heparin tube. Performed at IUHPL – Flow Cytometry)*

❒ **Microbiology Cultures** *(Dark green sodium heparin tube. Performed at IUHPL – Microbiology)* ○ AFB ○ Bacteria ○ Fungal ○ Viral ○ ISP

❒ **Molecular Diagnostics** *(Send two purple EDTA tubes. Performed at IUHPL - Molecular Department)*

○ AML mutations * ○ MDS mutation ○ MPN mutations ○ CMML mutations ○ JMML mutations ○ CML (ABL1) mutations

○ ALL mutations ○ CLL mutations ○ JAK2 (V617 F only) ○ Lymphoma/Myeloma mutations

○ FLT3 SR* – (Send out test to ARUP) [* FLT3 SR included in AML Mutations]

❒ **Bone Marrow Engraftment/Chimerism** *(Purple EDTA. Testing performed at IU Molecular Genetics Diagnostic Laboratory)*

❒ **Other, specify**_____

Procured by _____Lab Assistant_____ Phone Number _____

Rev 2-25-2016

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3) Physicians Signature	Order Date	Print Physicians Name (F, MI, L)		
Client (Clinic/Physician) Information			Group Physicians	
Send Additional Report To:				

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