

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

			HEA	Питапа	UIIIV	ersity Health	317.491.6 Fax: 317.4	000 or 800.433.0 91.6001	740		
1) Patient Legal Name (Last, First MI) DOB				2)		Date/Time of Collection	n				
Patient Social Security#	Race	M R#/Alternate Pt ID		() STAT		Phone Results To:					
Patient Address	Phone					Fax Results To:					
City, State, Zip			M F			TIENT/INS					
3) Physicians Signature	Order Date	Print Physiciar	ns Name (F,MI,I	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.							
Client (Clinic/Physician) Information				Group Physician	ıs		Company Na	Primary Insuran me:	ce		
							IU/Policy#	Gro up #	/Name:		
							Relationship to Patient:				
Notice: Medicare will only pay for tests that meet the Medicare definition of "Medical Necessity". Medicare may deny			5) ICD Diagnosis (Enter ALL that a			1	2	3			
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.				4		5	6	7	8		
			Bone Mai	row Pathology	Requi	sition					
Specimen Type				Clinical Informa	ation						
☐ BM Biopsy*CM ☐ BM Clot* *In 10% buffered formalin ☐				INITIAL STAGING FOLLOW-UP POST TRANSPLANT							
□ BIVI ASDITATE NO. TUDES DATK Green SOGIUM NEDGRIN EDTA				☐ Anemia ☐ Leukopenia/Neutropenia ☐ Thrombocytopenia ☐ Myelodysplastic s.							
							Lymphoma, sp	ecify			
					Plasma Cell Neoplasm, specify Myeloproliferative Neoplasm, specify						
24 hours; send peripheral	☐ Other, specify										
Additional Studies			•								
☐ Chromosome Analysis	(Karyotype) (D	ark green sodiur	n heparin tube.	Performed at IU Cy	ytogenet	tics Lab)					
☐ Fluorescence <i>In-Situ</i> Hy	bridization (FI	I SH) (Dark green	sodium hepari	n tube. Performed	at IU Cyt	togenetics Lab)					
☐ t (15:17) PML/RARA			□ -5/del(5	q) 🗖 de	1DS Pan el(7q)	□+8	□ del(20q)	Myeloma Pand □PDGFRA	□PDGFRB		
Other or individual p						nation regarding addition		bes, 317-278-65	28.		
☐ Cytochemical Stains (Ui					<i>y)</i> C	Iron Stain O BTE	О МРХ				
☐ Flow Cytometry (Dark g ☐ Microbiology Cultures					av) C	AFB O Bact	teria O Fung	al O Viral	O ISP		
☐ Molecular Diagnostics	-	•	-				icria O rang	ui O viiui	0 151		
O AML mutations * O ALL mutations	O MDS muta	ation O M ions O JA	PN mutations K2 (V617 F or	O CMML m	utation na/Mye	s O JMML mutati	ons O CML	(ABL1) mutatio	ons		
○ FLT3 SR* – (Send out ☐ Bone Marrow Engraftr				n AML Mutations] Trimed at IU Molecula		ics Diagnostic Laborato	rv)				
Other, specify	Cilillet 13	i dipic LDTA	resumy perjor	ca at 10 IVIOIECUIU	Jeneu	Les Diagnostic Laboratoi	71				

Lab Assistant

Phone Number

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Indiana University Health

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Patient Social Security#	Race	M R#/Alternate	e Pt ID			Phone Results To:					
Patient Address	!	Phone				FaxRes	sults To:				
City, State, Zip M F					В	ILL	FACIL	ITY / CI	LIENT		
3) Physicians Signature	Order Date	Print Physicians		() Split Bill: TC to Facility & PC to Insurance (Medicare, Medicaid) Attention PFN: do not register, send patient directly back to lab							
Client (Clinic/Physician) Information				Group	Physicians			<u> </u>			
Send Additional Report To:											
Sena Additional Report 10:											
			Bone Marro	ow Pathol	ogv Requisi	ition					
Specimen Type				linical Info	• •						
BM Biopsy*CM	☐ BM Clot*	*In 10% buffered	formalin 🗖	J INITIAL	☐ STA	GING	☐ FC	OLLOW-UP	☐ POST TI	RANSPLANT	
☐ BM Aspirate No. tubes	Dark green sodiun	n heparin E	DIA				-	Thrombocytope			
Control of the Contro					ukemia, specify						
☐ Peripheral Blood/Smears (Submit results of CBC/Diff performed within ☐ My					yeloproliferative Neoplasm, specifyher, specify						
Additional Studies											
☐ Chromosome Analysis (I	Karyotype) (Dari	k green sodium h	eparin tube. P	Performed at	IU Cytogeneti	cs Lab)					
☐ Fluorescence <i>In-Situ</i> Hyb	oridization (FISH	l) (Dark green so	dium heparin t	tube. Perfori	med at IU Cyto	ogenetics	Lab)				
☐ ALL Panel ☐ AML Panel ☐ CLL Panel ☐ Lymphoma Pa					☐ MDS Pane	el 🗆 N	1PN Panel	☐ Plasma Cell	Myeloma Pane	<u>!</u>	
, , ,	J MLL	☐ TP53	□ -5/del(5q))	□ del(7q)	- +	8	□ del(20q)	□PDGFRA	□PDGFRB	
☐ t (15:17) PML/RARA☐ Other or individual pr		No		Call III	ICI for inform	ation ros	ardina additi	onal available pro	shoe 217 270 CF	10	
☐ Cytochemical Stains (Uns		mears Performe	d at II IHDI 🗕 Sr			Iron Sta	_		ues, 317-276-032	20.	
☐ Flow Cytometry (Dark gre	·	•	•		•,.	1101130	0 512	O WII X			
☐ Microbiology Cultures (•	•		,	, .	AFB	О Вас	teria O Funga	al O Viral	O ISP	
☐ Molecular Diagnostics (S	•	•	•		•,.			Ü			
O AML mutations *	O MDS mutati	•	l mutations		1L mutations	11.0	MML mutat	tions O CML	(ABL1) mutatio	ns	
O ALL mutations	O CLL mutation	ns O JAK2	(V617 F only	y) O Lymp	ohoma/Myelo	oma mu	tations				
O FLT3 SR* – (Send out	•		included in A								
☐ Bone Marrow Engraftm	ent/Chimerism	(Purple EDTA. Te	esting perform	ed at IU Mol	ecular Genetic	cs Diagno.	stic Laborato	ory)			
Other, specify											

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