**Bone Marrow Pathology Requisition**

<table>
<thead>
<tr>
<th>Specimen Type</th>
<th>Clinical Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>BM Biopsy* _____</td>
<td>INITIAL</td>
</tr>
<tr>
<td>BM Aspirate No. tubes</td>
<td>Anemia</td>
</tr>
<tr>
<td>BM Aspirate Slides No. sent ___</td>
<td>Leukemia, specify__________</td>
</tr>
<tr>
<td>Peripheral Blood/Smears (Submit results of CBC/Diff performed within 24 hours; send peripheral smear with all bone marrows)</td>
<td>Plasma Cell Neoplasm, specify__________</td>
</tr>
<tr>
<td>Other, specify__________</td>
<td>Other, specify__________</td>
</tr>
</tbody>
</table>

**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)
- **Cytochemical Stains** (Unstained aspirate smears. Performed at IUHPL – Special Hematology)
- **Flow Cytometry** (Dark green sodium heparin tube. Performed at IUHPL – Flow Cytometry)
- **Microbiology Cultures** (Dark green sodium heparin tube. Performed at IUHPL – Microbiology)
- **Molecular Diagnostics** (Send 2 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 (V617F only)
  - FLT3 SR*
  - Other, specify__________
- **Bone Marrow Engraftment/Chimerism** (Purple EDTA. Testing performed at IU Molecular Genetics Diagnostic Laboratory)
- **Other, specify__________**

**Relationship to Patient:**

- **In-Situ Hybridization (ISH)** (Other or individual probes, specify__________)
- **Other or individual probes, specify__________**
- **Call IUCL for information regarding additional available probes, 317-278-6528.**

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**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.

**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.
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<tr>
<td>BM Clot*</td>
<td>STAGING</td>
</tr>
<tr>
<td>BM Aspirate</td>
<td>FOLLOW-UP</td>
</tr>
<tr>
<td>BM Aspirate Slides</td>
<td>MDS Panel</td>
</tr>
<tr>
<td>Peripheral Blood/Smears</td>
<td>POST TRANSPLANT</td>
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**Send Additional Report To:**

**Bill Facility / Client**

( ) Split Bill: TC to Facility & PC to Insurance (Medicare, Medicaid)

**Attention PFN:** do not register, send patient directly back to lab