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**	
3) Physicians Signature	Order Date	Print Physicians Name (F,MI,L)	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.	

Client (Clinic/Physician) Information	Group Physicians	Primary Insurance
		Company Name:
		IU/Policy# Group #/Name:
		Insurance Co. Address:
Send Additional Report To:		City: State/Zip:
		Policy Holder 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

****Please attach patient's most recent clinical history.**

FLOW CYTOMETRY

Please check one: ☐ **Inpatient** ☐ **Outptient** ☐ **Ambulatory Surg Center**

SPECIMEN TYPE:

☐ BONE MARROW Coll. Date_____Coll. Time_____
Transport using Sodium Heparin Preservative,
ROOM TEMP send aspirate smear no preservative SEND RESULTS OF CBC/DIFF PERFORMED WITHIN 24HRS.

☐ PERIPHERAL BLOOD Coll. Date_____Coll. Time_____
Transport using Sodium Heparin Preservative,
ROOM TEMP. Send wright stained PB smear.
SEND RESULTS OF CBC/DIFF PERFORMED WITHIN 24HRS.

☐ LYMPH NODE Coll. Date_____Coll. Time_____
Collection Site:_____

☐ FINE NEEDLE ASPIRATE Coll. Date_____Coll. Time_____
Collection Site:_____

Transport using RPMI 1640 Medium, **REFIGERATED NOT, FROZEN**

☐ OTHER TISSUE SPECIFY Coll. Date_____Coll. Time_____
Source____ _____

Transport using RPMI 1640 Medium, **REFIGERATED NOT, FROZEN**

Test

294 ☐ CD4 T CELL FOLLOW UP PANEL
293 ☐ CD4 T CELL INITIAL
245 ☐ LYMPHOMA PANEL
245 ☐ LEUKEMIA PROFILE
☐ PNH
223 ☐ T CELL SUBSETS
☐ T CELL SUBSETS/ B C ELL SUBSETS
☐ REGULATORY T-CELLS

FOR OPTIMAL TURN AROUND TIME, PLEASE CALL FLOW CYTOMETRY

PRIOR TO SENDING SPECIMEN **317-491-6550**

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Patient Social Security #	Race	MR#/Alternate Pt ID		Phone Results To:
Patient Address		Phone		Fax Results To:
City, State, Zip		M F	4) **BILL FACILITY / CLIENT**	
3) Physicians Signature	Order Date	Print Physicians Name (F, MI, L)	( ) 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	
Send Additional Report To:				

****Please attach patient's most recent clinical history.**

FLOW CYTOMETRY

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Transport using Sodium Heparin Preservative,
ROOM TEMP. Send wright stained PB smear.
SEND RESULTS OF CBC/DIFF PERFORMED WITHIN 24HRS.

☐ LYMPH NODE Coll. Date_____Coll. Time_____
Collection Site:_____

☐ FINE NEEDLE ASPIRATE Coll. Date_____Coll. Time_____
Collection Site:_____

Transport using RPMI 1640 Medium, **REFIGERATED NOT, FROZEN**

☐ OTHER TISSUE SPECIFY Coll. Date_____Coll. Time_____
Source____ _____

Transport using RPMI 1640 Medium, **REFIGERATED NOT, FROZEN**

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Test

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223 ☐ T CELL SUBSETS
☐ T CELL SUBSETS/ B C ELL SUBSETS
☐ REGULATORY T-CELLS