

Ship to: **Hematologics, Inc.**  
3161 Elliott Ave. Suite 200  
Seattle, WA 98121

Phone: (800) 860-0934 or (206) 223-2700  
FAX: (206) 223-5550  
Weekends & After Hours: (206) 264-4459

**HEMATOLOGICS USE ONLY**

**HLID#** \_\_\_\_\_

**PATIENT INFORMATION—ATTACH LABEL HERE**

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Specimen ID: \_\_\_\_\_

**BILLING INFORMATION**

Bill:  Client  Medicare  Insurance  Patient  
Hospital Status:  Inpatient  Outpatient  Non-patient  
\*Please attach face sheet with insurance information/patient demographics\*

**Ordering Physician Signature (Required):**

\_\_\_\_\_  
\*testing will be held pending physician signature\*

NPI: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

**SPECIMEN INFORMATION**

**Specimen Collection Date:** \_\_\_\_\_ **Specimen Collection Time:** \_\_\_\_\_

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Bone Marrow: Left PIC<br>_____ cc BM aspirate<br>_____ BM core Biopsy _____ cm length<br>_____ # aspirate smears<br>_____ aspirate clot | <input type="checkbox"/> Right PIC<br>_____ cc BM aspirate<br>_____ BM core Biopsy _____ cm length<br>_____ # aspirate smears<br>_____ aspirate clot | <input type="checkbox"/> Sternal<br>_____ cc BM aspirate<br>_____ # aspirate smears<br>_____ aspirate clot |
| <input type="checkbox"/> Peripheral Blood  | <input type="checkbox"/> Body Fluid Type/site: _____   |  |
| <input type="checkbox"/> Tissue Biopsy Type/site _____   | <input type="checkbox"/> Fine Needle Aspirate Site: _____  |  |
| <input type="checkbox"/> Paraffin Block  | <input type="checkbox"/> Paraffin Shavings for Molecular Testing (DNA only)  |  |

**DIAGNOSTIC STATUS—please attach chart notes / CBC / path reports and any other available clinical history**

- Suspected or ICD-10 code \_\_\_\_\_  Unknown  
Established Diagnosis \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Transplant (date): \_\_\_\_/\_\_\_\_/\_\_\_\_  autologous  allogeneic  same/opposite sex
- Diagnosis**  
Lymphoma:  Hodgkin  Non-Hodgkin Type: \_\_\_\_\_  
Leukemia:  ALL  AML  APL Type: \_\_\_\_\_  
 Multiple Myeloma  with  without Amyloidosis  
 MDS (Myelodysplastic Syndrome) Type: \_\_\_\_\_  
 MPN (Myeloproliferative Neoplasm) Type:  CML  ET  PV  CIMF
- Symptoms/Other**  
 Leukocytosis  Lymphocytosis  Neutrophilia  Erythrocytosis  Thrombocytosis  
 Leukopenia  Lymphopenia  Neutropenia  Anemia  Thrombocytopenia  
 Pancytopenia  Splenomegaly  Other: \_\_\_\_\_

**Comprehensive Evaluation**

- Morphology (with iron stain) and Flow Cytometry, with Cytogenetics, FISH, IHC and PCR as needed

**Flow Cytometry**

- Leukemia/Lymphoma Immunophenotyping  
 Reflex to Karyotyping/FISH/Molecular to confirm diagnosis if needed  
 PNH Panel

**Cell Sorting**

- Cell Sorting for Chimerism (CD3 & CD33)  
 CD19+ B-cells  NK-Cells  Other \_\_\_\_\_  
 Cell Sorting Tumor Population (flow required)

**Cytogenetics**

- Chromosome Analysis only  
 Chromosome Analysis with Reflex to FISH Analysis

**CGH/SNP Digital Karyotyping (Microarray)**

- MM  CLL  MDS  Other \_\_\_\_\_

**FISH Panels**

- |                                |                                      |  |
|--------------------------------|--------------------------------------|--|
| <input type="checkbox"/> AML   | <input type="checkbox"/> B-NHL*      | <input type="checkbox"/> Ph-Like ALL                 |
| <input type="checkbox"/> B-ALL | <input type="checkbox"/> T-NHL       | <input type="checkbox"/> AML Supplemental Panel      |
| <input type="checkbox"/> T-ALL | <input type="checkbox"/> Double Hit* | <input type="checkbox"/> MM                          |
| <input type="checkbox"/> MDS   | <input type="checkbox"/> CLLw/BCL1   | <input type="checkbox"/> Reflex to IgH Probe/s _____ |
| <input type="checkbox"/> MPN   | <input type="checkbox"/> CLLw/oBCL1  |  |
|                                | <input type="checkbox"/> CML         |  |
- \*Validated for Paraffin. Sections preferred. Please include H&E

**FISH Probes**

- |                                      |                               |                                 |                                       |
|--------------------------------------|-------------------------------|---------------------------------|---------------------------------------|
| <input type="checkbox"/> BCR-ABL     | <input type="checkbox"/> BCL2 | <input type="checkbox"/> PDGFRA | <input type="checkbox"/> (XX/XY)      |
| <input type="checkbox"/> PML-RARA    | <input type="checkbox"/> BCL6 | <input type="checkbox"/> PDGFRB | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> BCL1(CCND1) | <input type="checkbox"/> MALT | <input type="checkbox"/> FGFR1  |                                       |
|                                      | <input type="checkbox"/> MYC  | <input type="checkbox"/> JAK2   |                                       |

**Next Generation Sequencing**

- \*Preauthorization Requirements and Medicare Coverage Restrictions Apply\*
- AML:  Diagnostic (4 gene)  
 Reflex to Extended Panel  
 Monitoring MRD—Extended Panel  
 B-Cell Lymphoma Panel  MDS Panel  MPN Panel  
 Custom/Gene Specific MRD (Clinic Bill Only): \_\_\_\_\_

**Molecular Studies (May Require Preauthorization)**

- |  |   |
|--|---|
| <input type="checkbox"/> B-Cell Gene Rearrangement<br><input type="checkbox"/> Reflex to IGK         | <input type="checkbox"/> BCR-ABL Quantitative t(9;22) <sup>(2)</sup>                        |
| <input type="checkbox"/> T-Cell Gene Rearrangement<br><input type="checkbox"/> Reflex to T-Cell Beta | <b>If BCR-ABL negative, reflex to:</b><br><input type="checkbox"/> JAK2 Point Mutation      |
| <input type="checkbox"/> CLL IgHV Mutation Analysis  | <b>If JAK2 negative, reflex to:</b><br><input type="checkbox"/> Suspect PV Reflex to Exon12 |
| <input type="checkbox"/> MYD88 L265P   | <b>OR</b>   |
| <input type="checkbox"/> If Positive Reflex to CXCR4   | <input type="checkbox"/> Suspect ET/MF Reflex to MPL  |
| <input type="checkbox"/> AML Translocation Panel <sup>(1)*</sup>                                     | <input type="checkbox"/> Suspect ET/MF Reflex to CALR                                       |
| <input type="checkbox"/> AML1-ETO t(8;21) <sup>(1)*</sup>  | <input type="checkbox"/> CALR Mutation Analysis   |
| <input type="checkbox"/> PML-RARA t(15;17) <sup>(1)*</sup>   | <input type="checkbox"/> NUP98-NSD1 t(5;11) <sup>*</sup>                                    |
| <input type="checkbox"/> CBFβ-MYH11 inv(16) <sup>(1)*</sup>  | <input type="checkbox"/> NUP98-KDM5 t(11;12) <sup>*</sup>                                   |
| <input type="checkbox"/> ALL Translocation Panel <sup>(2)*</sup>                                     | <input type="checkbox"/> MLL-AF1 t(1;11) <sup>*</sup>                                       |
| <input type="checkbox"/> BCR-ABL Quantitative <sup>(2)</sup>   | <input type="checkbox"/> MLL-AF4 t(4;11) <sup>(2)*</sup>                                    |
| <input type="checkbox"/> E2A-PBX1 t(1;19) <sup>(2)*</sup>  | <input type="checkbox"/> MLL-AF9 t(9;11) <sup>*</sup>                                       |
| <input type="checkbox"/> MLL-AF4 t(4;11) <sup>(2)*</sup>   | <input type="checkbox"/> MLL-ENL/ELL t(11;19) <sup>*</sup>                                  |
| <input type="checkbox"/> TEL-AML1 t(12;21) <sup>(2)*</sup>   | <input type="checkbox"/> BCL-1 t(11;14) Monitoring <sup>*</sup>                             |
| <input type="checkbox"/> ABL Mutation Analysis (Gleevec Resistance)                                  | <input type="checkbox"/> BCL-2 t(14;18) Monitoring <sup>*</sup>                             |
| <input type="checkbox"/> c-Kit D816V Point Mutation  | <input type="checkbox"/> FIP1L1-PDGFRα del(4q12) <sup>*</sup>                               |
| <input type="checkbox"/> NPM-1 Mutation Analysis   | <input type="checkbox"/> WT1 RT PCR <sup>*</sup>  |
| <input type="checkbox"/> NPM1-MLF1 t(3;5)  | <input type="checkbox"/> CSF3R Mutation Analysis  |
| <input type="checkbox"/> CEBP Alpha Mutation   | <input type="checkbox"/> IDH1   |
| <input type="checkbox"/> CD33 SNP Genotyping   | <input type="checkbox"/> IDH2   |
| <input type="checkbox"/> STAT3 for T-LGL   | <input type="checkbox"/> BRAF for Hairy Cell Leukemia <sup>*</sup>                          |
| <input type="checkbox"/> SF3B1 Mutation Analysis   | <input type="checkbox"/> CBFA2T3-GLIS2 RT PCR <sup>*</sup>                                  |
| <input type="checkbox"/> CXCR4   |   |
- (1) AML Panel  
(2) ALL Panel  
\*QUANTITATIVE

**REPORTING:**

**FAX report to:** (\_\_\_\_) \_\_\_\_\_ **Attn:** \_\_\_\_\_

**Submitting Institution:** \_\_\_\_\_