MOLECULAR DIAGNOSTICS LABORATORY

REQUISITION & PHYSICIAN ORDER FORM

ICD-9 Code/Diagnosis: 

Collected by: 

Collected Date: 

Collection Time: 

Attending Physician: (If different from above) 

TESTING WILL BE DELAYED OR NOT PERFORMED IF REQUISITION IS NOT COMPLETE!

SPECIMEN TYPE

☐ BLOOD ☐ BONE MARROW ☐ PARAFFIN BLOCK

☐ TISSUE (SEND FROZEN) SOURCE ☐ OTHER SOURCE

SURG Path ID# 

HEMATOLOGY/ONCOLOGY

☐ KIT D816V Mutation Detection

☐ IGH/BCL2 t (14; 18) Translocation Detection

☐ TCR gamma PCR

☐ PML/RARA t (15; 17) Translocation Detection

☐ IGH by PCR

☐ FLT3 Mutation Detection

☐ t (x; 18) SYT/SSX Translocation Detection

GENETICS

☐ Apolipoprotein E Genotype by DNA Analysis

☐ Factor V Leiden Mutation Detection by DNA Analysis

☐ Prothrombin 20210 Mutation Detection by DNA Analysis

☐ MTHFR Mutation Detection by DNA Analysis C677T

☐ Hereditary Hemochromatosis Mutation Detection by DNA Analysis

☐ CYSTIC FIBROSIS CARRIER SCREEN (MUST INCLUDE PATIENT HISTORY FORM)

☐ Other __________________________

BONE MARROW TRANSPLANT ENGRAFTMENT ASSESSMENT

☐ Pre-BMT RECIPIENT, Engraftment Analysis

☐ Pre-BMT DONOR, Engraftment Analysis

DONOR FOR: 

Name: ____________________

Reg#: ____________________

Post-BMT Engraftment Analysis

(Pre-BMT must have been previously performed)

Non-myeloablative transplant? ☐ Yes ☐ No

Fractionation? ☐ Yes ☐ No

☐ 30 days

☐ 100 days

☐ 1 year

☐ Other ____________________

SPECIMEN CODES:

TUBES

L = LAVENDER

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