

PATHOLOGY
TESTING / DIAGNOSTIC / SCREENING
REQUISITION - FLOW CYTOMETRY
LABORATORY REQUISITION & PHYSICIAN ORDER

RESULTS REPORTING LOCATION CODE:

- Routine
 STAT

ORDER DATE: ____/____/____
 (mm/dd/yyyy)

MRN
 NAME
 BIRTHDATE
 CSN

ICD-9 Code/Diagnosis:		Ordering Clinician to receive report: <input type="checkbox"/> See label above	
Collected by:			UMHS Dr. #: _____
Collected Date: ____/____/____	Collection Time: ____:____am/pm	Attending Physician: (if different from above)	UMHS Dr. #: _____

FLOW CYTOMETRY LABORATORY

EVENINGS AND WEEKENDS CALL 936-6866 FOR INFORMATION AND PAGER NUMBER

RESPONSIBLE STAFF PHYSICIAN PAGER NO. _____ HOUSE OFFICE PAGER NO. _____

SPECIMEN TYPE:

- Blood
 Bone Marrow
 Lymph Node
 CSF
 Apheresis Product
 Other _____

**** LEUKS LEUKEMIA/LYMPHOMA IMMUNOPHENOTYPING G**

HISTORY/DIAGNOSIS/HEMATOLOGIC DATA **(THIS INFORMATION IS ESSENTIAL FOR PROCESSING!)**:

PCL MULTIPLE MYELOMA-MRD BM

This specimen is submitted for MM-MRD testing to determine whether "stringent" criteria for a complete response (sCR) are met

IMMUNE MONITORING

- I3 ACQUIRED IMMUNODEFICIENCIES Y AND L***
 (T-Cell Subsets CD3, CD4, CD8)
 * (Send Lavender tube to Hematology for CBC and Differential: absolute counts cannot be reported unless all specimen requirements are met.)
 HIV Antibody Positive
 Non-HIV Viral Infection
 Other (Specify) _____

- BAL3 ACQUIRED IMMUNODEFICIENCIES BF**
 (T-Cell Subsets CD3, CD4, CD8 **on BRONCHOALVEOLAR specimen**)

- IMM PRIMARY IMMUNODEFICIENCIES Y AND L***
 (B, T and NK Cell Subsets)
 * (Send Lavender tube to Hematology for CBC and Differential: absolute counts cannot be reported unless all specimen requirements are met.)

Clinical Dx _____

- SCIDS Check here for **SCIDS panel-includes** CD45RA/RO subsets **(by State referral only, infants <4 months old)**

- DERMF DERM PANEL Y AND L***
 * (Send Lavender tube to Hematology for CBC and Differential: absolute counts cannot be reported unless all specimen requirements are met.)

THERAPY MONITORING

- TXP ORGAN TRANSPLANT Y AND L***
 (CD3 Count)
 * (Send Lavender tube to Hematology for CBC and Differential: absolute counts cannot be reported unless all specimen requirements are met.)

- Pre-Transplant
 Rejection
 OKT3 Therapy
 ALG/ATGAM Therapy

- CD34**
 Peripheral Stem Cell Collection for BMT
 Peripheral Stem Cell Donor

Specimen Type/Clinical DX _____

- RITUX RITUXIMAB/RITUXAN THERAPY Y AND L***
 * (Send Lavender tube to Hematology for CBC and Differential: absolute counts cannot be reported unless all specimen requirements are met.)

MISCELLANEOUS SPECIALIZED LEUKOCYTE ASSAYS

- ** PNH (suspected paroxysmal nocturnal hemoglobinuria) Y**

** Please note: Additional testing and/or charges may be associated with this test. Please refer to on-line handbook, <http://www.pathology.med.umich.edu/handbook/>