MPA
MORRISTOWN PATHOLOGY ASSOCIATES
MORRISTOWN, NJ • 973-867-7298

DT101

HEMATOLOGY / ONCOLOGY PATHOLOGY REQUISITION

PATIENT

NAME: Last / First

STREET / APT #:

CITY / STATE / ZIP:

PHONE #: | DATE OF BIRTH:

SOCIAL SECURITY #: | SEX: ☐ Male ☐ Female

BILLING INFORMATION

ATTACH INSURANCE FACE SHEET IF AVAILABLE

INSURANCE - PRIMARY *Please attach copy of insurance card*

CARRIER: | SUBSCRIBER: | DOB:

☐ Commercial ☐ HMO
☐ Medicare ☐ Medicaid

INSURANCE ID #: | GP #:

INSURANCE - SECONDARY

CARRIER: | INSURANCE ID #:

PROCEDURE DATE:

PHYSICIAN

DOCTOR NAME:

PRE-OPERATIVE DX / ICD-10 CODE:

CLINICAL INFO:

____
____
____

SPECIMEN TYPE: ☐ BM ☐ PB ☐ FNA ☐ Lymph Node ☐ Body Fluid

☐ BONE MARROW MORPHOLOGY

(Core & Clot in Formalin, Smears in Slide Carrier)

☐ Analysis: Core / Clot / Smears
☐ Please Return Smears

☐ FLOW CYTOMETRY (FCM)

FCM PANELS
(2mL heparinized/EDTA marrow, 5mL heparinized/EDTA blood)

Panel	
☐ Acute Leukemia	AML / ALL
☐ Myelodysplasia	MDS
☐ PNH - Peripheral Blood	
☐ Myeloproliferative	CML / Other
☐ Lymphoma B & T / Chronic Leukemia	(CLL)
☐ Plasma Cell Dyscrasia	
☐ Other: ______________________	

☐ CYTOGENETICS (CG)

(2mL heparinized/EDTA marrow, 5mL heparinized/EDTA blood)

☐ REFLEX TO FISH PROBES IF CG NEGATIVE

** Each test can be ordered separately or as a panel*

☐ MOLECULAR STUDIES

☐ FISH PROBES

Probe	
☐ BCR-ABL t(9;22)	CML/AML/ALL
☐ PML-RARA t(15;17)	AML-M_3/APL
☐ CBFB inv(16)	AML-M_4eo
☐ AML_1/ETO t(8;21)	AML-M_2
☐ BCL_1/IGH t(11;14)	MCL
☐ IGH/BCL_2 t(14;18)	FCL
☐ MDS Panel*	11q23, +8, -5/5q-, -7/7q-, 20q-
☐ Myeloma Panel*	RB1, p53, (t(11;14), t(4;14), 14q32, t(14;16)
☐ CLL Panel*	+12, ATM, t(11;14), RB1, p53
☐ MDS Panel, Reflex if CG Neg	-(14;16)
☐ BCL6/IGH	
☐ MYC/IGH	
☐ High Grade Lymphoma (HGL) Panel	
☐ UroVysion	

☐ PCR / RT-PCR - LAVENDER TUBE

☐ BCR/ABL
☐ JAK-2
☐ PML - RARA t(15;17)
☐ RCBFB inv(16)
☐ IGH B-cell Clonality
☐ T Gamma T-cell Clonality
☐ FLT3
☐ Other
☐ NPM
☐ CEBPA
☐ C KIT
☐ Other

☐ DNA SEQUENCING/MUTATION ANALYSIS

☐ CLL: *IGHV* Mutation

Patient Signature: ______________________ Date: __________ Time: __________

Physician Signature: ______________________ UPIN#: __________ Date: __________ Time: __________

NOT PART OF THE PERMANENT RECORD

LAB USE ONLY ☐ Core ☐ Aspirate / G / L ☐ Clot ☐ Smears __________

MPA1 (10/20)