

PATIENT INFORMATION					
Last Name		First Name		M.I.	
Street Address				Apt. #	
City			State	Zip	
Phone Number		Social Security Number			
Date of Birth / /	Age	Sex	Client ID #	Collection Date	

CLIENT INFORMATION	
Treating Physician	UPIN #
Physician's Signature X _____	

BILLING / INSURANCE (attach copy of insurance card - both sides)			
Bill:	Subscriber Insurance <input type="checkbox"/> Secondary Insurance Information Attached		
<input type="checkbox"/> Insurance	Name / Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent		
<input type="checkbox"/> Medicare	Company Name		
<input type="checkbox"/> Medicaid	Address		
<input type="checkbox"/> Worker's Comp	City	State	Zip
<input type="checkbox"/> Patient	Employer Name		
<input type="checkbox"/> Physician	Subscriber DOB / /	Group/Contract	Member ID#
<input type="checkbox"/> Hospital	Subscriber Sex	Medicare#	Medicaid ID#
<input type="checkbox"/> Other	<input type="checkbox"/> Male <input type="checkbox"/> Female		
<input type="checkbox"/> Outpatient/ Non-hospital			
<input type="checkbox"/> Hospital/ (IP/OP/ER)			

Send Duplicate of Report to:

Name _____

Address/Fax _____

ICD-9 CODE (Required) _____

CLINICAL INFORMATION
INDICATIONS
<input type="checkbox"/> Anemia <input type="checkbox"/> Thrombocytopenia <input type="checkbox"/> Leukopenia
<input type="checkbox"/> Leukocytosis <input type="checkbox"/> Thrombocytosis <input type="checkbox"/> Erythrocytosis
<input type="checkbox"/> Monoclonal gammopathy: ___ IgM ___ IgG ___ IgA ___ Kappa ___ Lambda
<input type="checkbox"/> Lymphadenopathy <input type="checkbox"/> Splenomegaly
<input type="checkbox"/> Lymphoma/Cancer Staging
DIAGNOSIS <input type="checkbox"/> Under Consideration <input type="checkbox"/> Confirmed
<input type="checkbox"/> Acute Leukemia
<input type="checkbox"/> NOS <input type="checkbox"/> AML <input type="checkbox"/> ALL
<input type="checkbox"/> Myelodysplastic Syndrome (MDS)
<input type="checkbox"/> Myeloproliferative Disorder
<input type="checkbox"/> CML <input type="checkbox"/> CMMoL <input type="checkbox"/> Myelofibrosis <input type="checkbox"/> P Vera <input type="checkbox"/> ET
<input type="checkbox"/> Non-Hodgkin's Lymphoma: Type _____
<input type="checkbox"/> Hodgkin Lymphoma
<input type="checkbox"/> Chronic Lymphoproliferative Disorder
<input type="checkbox"/> CLL <input type="checkbox"/> HCL <input type="checkbox"/> NK Cell
<input type="checkbox"/> Multiple Myeloma
<input type="checkbox"/> Other _____
STATUS <input type="checkbox"/> New DX <input type="checkbox"/> Post TX ___ Days <input type="checkbox"/> Relapse
Previous Bone Marrow <input type="checkbox"/> Yes <input type="checkbox"/> No

SPECIMEN INFORMATION (A separate report will be generated for each body site submitted.)
Collection Date _____ Time _____ : _____ <input type="checkbox"/> AM <input type="checkbox"/> PM
Bone Marrow Biospy / Aspirate: <input type="checkbox"/> Lt <input type="checkbox"/> Rt Iliac Crest Biopsy
<input type="checkbox"/> Marrow Clot
<input type="checkbox"/> Smears/Touch Preps: # Aspirate Smears _____ # Biopsy Touch Preps _____
<input type="checkbox"/> # Peripheral Smears _____ (Please submit fingerstick smear if no CBC is drawn)
<input type="checkbox"/> BM Aspirate Tube(s): # Sodium Heparin (Green) _____ # EDTA (Purple) _____
<input type="checkbox"/> Peripheral Blood Tube: # EDTA (Purple) _____
<input type="checkbox"/> Copy of CBC Results
<input type="checkbox"/> Consultation of outside slides: # Stained _____ # Unstained _____
COMMENTS:

87257

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