PRECISION PATHOLOGY
"A Spirit of Excellence"

Dr. Stoll (210) 757-8399
Dr. Ackley (210) 271-3050

Lab Use Only:
Tech Initial:_____
Accession #:_____
Date/Time:_____

HEMATOPATHOLO REQUISITION

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 #

BILLING / INSURANCE (attach copy of insurance card - both sides)

Bill:
- ☐ Insurance
- ☐ Medicare
- ☐ Medicaid
- ☐ Worker's Comp
- ☐ Patient
- ☐ Physician
- ☐ Other

- ☐ Outpatient/ Non-hospital
- ☐ Hospital/ (IP/OP/ER)

Subscriber Insurance ☐ Secondary Insurance Information Attached

Name / Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Dependent

Company Name

Address

City	State	Zip

Employer Name

Subscriber DOB / /	Group/Contract	Member ID#
Subscriber Sex ☐ Male ☐ Female	Medicare#	Medicaid ID#

CLIENT INFORMATION

Treating Physician	UPIN #

Physician's Signature X _____

Send Duplicate of Report to:

Name _____

Address/Fax _____

ICD-9 CODE (Required) _____

CLINICAL INFORMATION

STATUS ☐ New DX ☐ Post TX ____ Days ☐ Relapse

INDICATIONS

☐ Anemia ☐ Thrombocytopenia ☐ Leukopenia

☐ Leukocytosis ☐ Thrombocytosis ☐ Erythrocytosis

☐ Monoclonal gammopathy:

____IgM ____IgG ____IgA ____Kappa ____Lambda

☐ Lymphadenopathy ☐ Splenomegaly

☐ Lymphoma/Cancer Staging

DIAGNOSIS ☐ Under Consideration ☐ Confirmed

☐ Acute Leukemia

☐ NOS ☐ AML ☐ ALL

☐ Myelodysplastic Syndrome (MDS)

☐ Myeloproliferative Disorder

☐ CML ☐ CMMoL ☐ Myelofibrosis ☐ P Vera ☐ ET

☐ Non-Hodgkin's Lymphoma: Type _____

☐ Hodgkin Lymphoma

☐ Chronic Lymphoprofilerative Disorder

☐ CLL ☐ HCL ☐ NK Cell

☐ Multiple Myeloma

☐ Other _____

Previous Bone Marrow ☐ Yes ☐ No

SPECIMEN INFORMATION (A separate report will be generated for each body site subm

Collection Date _____ Time _____ : _____ ☐ AM ☐ PM

Left Side Bone Marrow	**Right Side Bone Marrow**
☐ ____ Biopsy Left Iliac Crest	☐ ____ Biopsy Right Iliac Crest
☐ ____ Clot Left Side	☐ ____ Clot Right Side
☐ ____ Aspirate Smears Number of Slides:_____	☐ ____ Aspirate Smears Number of Slides:_____
☐ ____ Touch Preps Number of Slides:_____	☐ ____ Touch Preps Number of Slides:_____

☐ ____ Peripheral Smears/Blood
(Please submit fingerstick smear if no CBC is drawn.)
Number of Slides:_____ / Number of Tubes:_____

☐ ____ Sodium Heperin Tube (green) Number of Tubes:_____	☐ ____ Sodium Heperin Tube (gr Number of Tubes:_____
☐ ____ EDTA Tube (purple) Number of Tubes:_____	☐ ____ EDTA Tube (purple) Number of Tubes:_____

☐ Copy of CBC Results

☐ Consultation of outside slides:
Number of Stained:_____ Number of Unstained:_____

COMMENTS: