UR MEDICINE | Labs

#Specimens:		Depot:	
Collect Date:	Time:	By:	ABN Signed: ☐
MR #:	A #:		

STAT

REQUIRED (PRINT OR PATIENT LABEL)

Name (Last, First, MI):

Date of Birth: | Sex: (Circle) M F

Street Address:

Street Address 2:

City, State, Zip:

Phone Number: | Chart Number:

Billing Information:
Select Specialty Billing (Client Billing) OR Insurance

☐ **SPECIALTY BILLING: Lab - BHC**

OR

☐ Aetna ☐ Medicaid ☐ MVP Gold
☐ Blue Choice/Shield ☐ Medicare ☐ Other: _____
☐ Blue Choice ☐ MVP
☐ Blue Choice Medicare

Subscriber ID: _____

Subscriber's Name: _____

Relationship to Subscriber: _____

Bassett Medical Center (RFL) **2BHC**
1 Atwell Rd
Cooperstown, NY 13326
Phone: (604) 547-3456 Fax: (607) 547-6717

☐ (ANJFC) ALLERTON, JEFFREY MD
☐ (CYM8B) CANARY, MARCY LYNN MD
☐ (CNTCA) CHAPMAN, TIMOTHY MD
☐ (FKJAA) FISK, JOHN MD
☐ (HSDCB) HILLS, DAY MD
☐ (MEAN1A) MCKANE, ANN MD
☐ (POSBA) PARYLO, SARA MD
☐ (PLAFA) PATEL, ANUSH MD
☐ (SYS8B) SASTRY, SIMHA MD
☐ (SRDXA) SCHREIBER, DANIEL MD
☐ (HDH3A) HEAD, HILARI, NP
☐ _____

Phone Results to: Fax Results to:

Ordering Provider's Signature: Date of Signature:

Diagnosis Mandatory: Signs/Symptoms or ICD10 Codes
If ordered for screening, list test name here and write "SCREENING" after it

Send Additional Reports to: (Full Name/Address)

Compliance is Mandatory and Regulated. For the laboratory to properly and receive payment for tests ordered on Medicare Beneficiaries, specific ICD-10 code(s) or a descriptive diagnosis must be included on each patient for each test ordered. It is critical that the diagnosis provided to the lab is consistent with those recorded in the patient medical record on the of service.

SPECIMEN TYPE SUBMITTED (For Peripheral Blood please use seperate UR Medicine Labs PERIPHERAL BLOOD ONLY requisition)

☐ Bone Marrow Aspirate
☐ Bone Marrow Core Biopsy
☐ Fine Needle Aspirate
☐ Needle Core Biopsy
☐ Lymph Node Tissue
☐ Spleen Tissue
☐ Other Tissue (Type:_____)

STUDIES REQUESTED

FLOW CYTOMETRY

☐ (18240) Flow Cytometry for lymphoma/leukemia workup & Hematopathology review

CYTOGENETICS

☐ (25789) Chromosome Analysis (Karotype)
☐ (16807) FISH: _____
(indicate FISH probes to run)

MOLECULAR DIAGNOSTICS

All paraffin embedded samples must be sent through histology for processing

☐ (CHIMS) Chimerism ☐ Donor ☐ Pre-transplant Recipient ☐ Post-transplant Recipient
☐ (BRFMT) BRAF
☐ (32206) FLT3 (ITD and TKD D835/I836)
☐ (42253) JAK2 Gene, V617F Mutation ☐ with Reflex CALR
☐ (CALR) Mutations in Exon 9 of the Calrecticullin Gene (Non-reflexed)
☐ (34682) MYD88 with reflex to CXCR4
☐ (IGKG) IGK B-Cell Clonality Ig Kapa Screening Assay by PCR
☐ (36680) IGH B-Cell Clonality Ig Heavy Chain Screening Assay by PCR
☐ (IGHVG) IGHV Mutation Analysis
☐ (37343) TCRG T-Cell Clonality Screening by PCR
☐ (MSI) Microsatellite Instability (Solid tumor only)
☐ (STMP) Oncomine Focus Assay 35 gene NGS panel (Solid tumor only)
☐ (GNFS) Lung cancer fusion panel
(ALK, ROS1, and RET fusions, MET exon 14 skipping) (Solid tumor only)

RELEVANT CLINICAL HISTORY (CHECK ALL THAT APPLY)

☐ Previous bone marrow biopsies/aspirate, Date(s): _____
☐ History of leukemia or lymphoma (note specifc history in other releveant info area)
☐ History of myeloma (R/O Myeloma)
☐ Recent history of growth factor treatment
☐ Workup for myelodysplasia
☐ Anemia
☐ Neutropenia
☐ Thrombocytopenia
☐ Other Cytopenias
☐ CBC Findings (Please enter relevant numbers):

Hemoglobin/Hematocrit: _____
Total WBC: _____
Plate Count: _____

Other relevant information (Please write below):

_____
_____
_____
_____
_____

Relevant Differential Findings (Blasts, Increased Basophils, Eosinophilia, etc.) - Please specify: _____