#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
☐ Blue Choice/Shield
☐ Blue Choice
☐ Blue Choice Medicare
☐ Medicaid
☐ Medicare
☐ MVP
☐ MVP Gold
☐ Other: ___________

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.

PERIPHERAL BLOOD ONLY

☐ Peripheral Blood*

* **Genetic Studies ordered on peripheral blood do not include hematopathology review**

STUDIES REQUESTED

FLOW CYTOMETRY

☐ (18240) Flow Cytometry lymphoma/leukemia work up & Hematopathology review
☐ (33517) Lymphocyte subset testing (CD4/CD8)- T-cells only
☐ (28695) Lymphocyte subset testing- T & B cell subsets
☐ (44198) Paroxysmal Nocturnal Hemoglibinuria (PNH) Workup (GPI-linked protein studies)

Genetic Studies:

CYTOGENETICS

☐ (25789) Chromosome Analysis (Karotype)

(16807) Peripheral Blood FISH
☐ CML Panel: t(9;22) BCR-ABL1
☐ CLL Panel: 11q22(ATM)/17p13 (TP53), 12cen/13q14.3, t(11:14) (CCND1, IGH)
☐ MDS Panel: 5/5q-, -7/7q-, 8cen, 20q12, Xcen/Ycen

MOLECULAR DIAGNOSTICS

☐ (22220) BCR-ABL1, Major (p210) RT-PCR t 9:22 (Deliver specimen on ice)
☐ (MCMP) Oncomine Myeloid Assay 45 gene NGS panel

RELEVANT CLINICAL HISTORY (CHECK ALL THAT APPLY)

☐ History of leukemia or lymphoma (note specifc history in other releveant info area)
☐ History of CML
☐ History of CLL
☐ History of MDS
☐ Anemia
☐ Neutropenia
☐ Thrombocytopenia
☐ Other Cytopenias
☐ CBC Findings (Please attach CBC and Differential):

Other relevant information (Please write below):

____

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