HEMATOPATHOLOGY REQUISITION FORM

Associated Laboratory Physicians, SC – Diagnostic Pathology Consultants, SC.

Ingalls Memorial Hospital One Ingalls Drive Harvey, IL 60426 708-915-5763 FAX 708-915-3786	Westlake Hospital 1225 W. Lake St. Melrose Park, IL 60160 708-938-7220 FAX 708-938-9388

Physician Information

Doctor(s) Name/Office/Clinic:

Date of Service: Fax/Call Results to #: Stat: ☐

Patient Information

Patient's Name:		Address Number & Street:	
City:		State:	Zip Code:
Date of Birth:	Social Security #:		Sex: M ☐ F ☐

Specimen Information

Date/Time of Collection:

Bone Marrow Biopsy R ☐ L ☐	Bone Marrow Aspirate R ☐ L ☐	Peripheral Blood ☐	Other :

Test(s) Requested:

Comprehensive bone marrow evaluation
(includes morphology, flow, Cytogenetics, IHC, Molecular, and FISH as determined by the Hematopathologist)

Chromosome studies	**Molecular (PCR)**	**FISH**	**Microbiology Studies**
Flow Cytometry	BCR/ABL (Quantitative)	MDS Panel	Routine
Comprehensive analysis	JAK-2	MM/MGUS Panel	Fungal
ZAP70 Panel	FLT3 & NPM1	AML Panel	AFB
PNH Panel	PML/RARA	CLL Panel	Viral
Other	Other	Other	Other

Clinical Diagnosis:

Please Include CBC if Available and ICD-9 Code

Insurance Information

****Please attach a copy of the patient's insurance card****

Insurance Company and Plan Name: ____________________

Insurer's ID# ____________________ Group Number ____________________

Policy Holder's Name ____________________ Relationship to Insured: Self ____ Spouse ____ Child ____ Other ____

Lab Use Only: