

Informed Consent Obtained

ID Checked

BONE MARROW REQUEST FORM



**PHYSICIANS
LABORATORY**

focused on excellence

SIOUX FALLS, SD
MITCHELL, SD

SPENCER, IA
YANKTON, SD

Client Services: (605) 322-7212 • (800) 658-5474
Website: www.plpath.com

SEX	DATE OF BIRTH	DATE COLLECTED
SOCIAL SECURITY NO.		
PRINT PATIENT NAME – FIRST, MIDDLE, LAST		
STREET		APT. NO.
CITY	STATE	ZIP

TELEPHONE NO. ()	RESPONSIBLE PARTY & ADDRESS (if other than patient.)
BILL TO: <input type="checkbox"/> SUBMITTING CLINIC <input type="checkbox"/> PATIENT / INS <input type="checkbox"/> MEDICARE / MEDICAID <input type="checkbox"/> INPATIENT <input type="checkbox"/> OUTPATIENT	
MEDICARE I.D. NO.	MEDICAID (WELFARE) NO.
INSURANCE COMPANY NAME, ADDRESS	
INSURED'S I.D. NO.	INSURED'S GROUP NO.
CHART NUMBER	DIAGNOSIS CODE

CLINIC CODE

SUBMITTING PHYSICIAN
PHYSICIAN / PROVIDER SIGNATURE

NOTE → **CBC WITH DIFFERENTIAL REQUIRED WITHIN 24 HOURS OF BIOPSY**

1. Clinical Information

Known Malignancy _____

Diagnosis(es) under Consideration:

- | | |
|---|---|
| <input type="checkbox"/> Leukocytosis | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Erythrocytosis | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> Lymphocytosis | Type: _____ |
| <input type="checkbox"/> Thrombocytosis | <input type="checkbox"/> Plasma Cell Myeloma/MGUS <input type="checkbox"/> MM IHC |
| <input type="checkbox"/> Pancytopenia | <input type="checkbox"/> Amyloidosis |
| <input type="checkbox"/> Neutropenia | <input type="checkbox"/> MDS (Myelodysplastic Syndrome) |
| <input type="checkbox"/> Thrombocytopenia | <input type="checkbox"/> MPN (Myeloproliferative Neoplasm) |
| <input type="checkbox"/> Leukopenia | Type: <input type="checkbox"/> CML <input type="checkbox"/> ET <input type="checkbox"/> PV <input type="checkbox"/> PMF |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Unknown/Undiagnosed |
| | <input type="checkbox"/> Other: _____ |

Status:

- | | |
|--|--|
| <input type="checkbox"/> Suspected/Unknown | <input type="checkbox"/> Established Diagnosis (date): _____ |
| <input type="checkbox"/> Post-transplant (date): _____ | <input type="checkbox"/> autologous |
| | <input type="checkbox"/> allogeneic: <input type="checkbox"/> same sex <input type="checkbox"/> opposite sex |
| | <input type="checkbox"/> matched unrelated donor |

Additional Information

Specimen Information:

- | | |
|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| _____ mL BM aspirate | _____ mL BM aspirate |
| _____ BM core Biopsy _____ cm length | _____ BM core Biopsy _____ cm length |

FOR LAB USE ONLY – DO NOT WRITE OR PLACE A LABEL BELOW THIS LINE

Reflex Testing per Pathologist

2. Flow Cytometry

Acceptable specimen types:

≥3mL PB or 2mL BM aspirate, Green Top Tube (Na Heparin) (EDTA/ACD accepted, not preferred)

Fresh Tissue in Tissue Culture Medium (RPMI), Effusions in RPMI with 10 units heparin/mL

CSF (≥1 mL) in = volume RPMI BAL 100-150 mL irrigation fluid in = volume RPMI

- Leukemia/Lymphoma Immunophenotyping (with reflex testing if needed to confirm diagnosis)
- MRD by flow cytometry
- PNH flow (peripheral blood)

3. Cytogenetics (Chromosome Analysis)

Acceptable specimen types:

Bone marrow or peripheral blood, Green Top Tube (Na Heparin), fresh tissue in tissue culture media

- Conventional Cytogenetic Studies
- Digital Karyotype by CGH Microarray (requires preauthorization) (e.g. myeloma, CLL, MDS)

4. FISH Panels:

- | | | |
|---|--|---|
| <input type="checkbox"/> ALL | <input type="checkbox"/> AML | <input type="checkbox"/> MDS |
| <input type="checkbox"/> MM | <input type="checkbox"/> MPN | <input type="checkbox"/> CML |
| <input type="checkbox"/> Double-Hit
Lymphoma | <input type="checkbox"/> CLL with BCL1 | <input type="checkbox"/> CLL without BCL1 |

Individual FISH Probes:

- | | | |
|----------------------------------|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> BCR-ABL | <input type="checkbox"/> PML-RARA | <input type="checkbox"/> BCL1(CCND1) |
| <input type="checkbox"/> BCL2 | <input type="checkbox"/> BCL6 | <input type="checkbox"/> MALT |
| <input type="checkbox"/> MYC | <input type="checkbox"/> PDGFRA | <input type="checkbox"/> PDGFRB |
| <input type="checkbox"/> FGFRI | <input type="checkbox"/> (XX/XY) | <input type="checkbox"/> Other |

5. Molecular Studies:

(Non-Medicare Patients Require Preauthorization)

- | | | |
|---|---|---|
| <input type="checkbox"/> B-Cell Gene Rearrangement | <input type="checkbox"/> If Neg Reflex to IGK | <input type="checkbox"/> E2A-PBX1 t(1;19) |
| <input type="checkbox"/> T-Cell Gene Rearrangement | <input type="checkbox"/> If Neg Reflex to T-Cell Beta | <input type="checkbox"/> MLL-AF1 t(1;11) RT PCR |
| <input type="checkbox"/> BCR-ABL Quantitative t(9;22) | | <input type="checkbox"/> MLL-AF4 t(4;11) RT PCR |
| <input type="checkbox"/> JAK2 Point Mutation Detection | | <input type="checkbox"/> MLL AF9 t(9;11) RT PCR |
| <input type="checkbox"/> If Neg Reflex to Exon 12 | | <input type="checkbox"/> MLL-EN/ELL t(11;19) RT PCR |
| <input type="checkbox"/> If Neg Reflex to MPL | | <input type="checkbox"/> BCL-1 t(11;14) Monitoring |
| <input type="checkbox"/> If Neg Reflex to CALR | | <input type="checkbox"/> BCL-2 t(14;18) Monitoring |
| <input type="checkbox"/> CLL IgHV Mutation Analysis | | <input type="checkbox"/> FIP1L1-PDGFR del (4q12) |
| <input type="checkbox"/> NPM-1 Mutation Analysis | | <input type="checkbox"/> MYD88 L265P |
| <input type="checkbox"/> ABL Mutation Analysis (Gleevec Resistance) | | <input type="checkbox"/> CSF3R Mutation Analysis |
| <input type="checkbox"/> CEBP Alpha Mutation Analysis | | <input type="checkbox"/> BRAF for Hairy Cell Leukemia |
| <input type="checkbox"/> c-Kit D816V Point Mutation Detection | | <input type="checkbox"/> IDH1 |
| <input type="checkbox"/> PML-RARA t(15;17) | | <input type="checkbox"/> IDH2 |
| <input type="checkbox"/> AML1-ETO t(8;21) | | <input type="checkbox"/> CXCR4 |
| <input type="checkbox"/> NUP98-NSD1 t(5;11) | | <input type="checkbox"/> STAT3 for T-LGL |
| <input type="checkbox"/> CBFβ-MYH11 inv(16) | | <input type="checkbox"/> SF3B1 |
| <input type="checkbox"/> TEL-AML1 t(12;21) | | |

6. Next Gen Sequencing:

(*Non-Medicare Patients Require Preauthorization*)

- AML NGS 4 Marker Panel (NPM1, FLT3, c-Kit, CEBP Alpha)
 - Reflex to Extended Panel
 - MRD Monitoring Panel
- MDS NGS Panel
- MPN NGS Panel

7. Chimerism Studies (EDTA Tubes and ARUP form required)

Time: _____ Date: _____ Physician Signature: _____