U I D L
UI Diagnostic Laboratories

Client Services Toll-Free: 1-866-UIHC LAB
Local: 319-384-7212
Fax: 319-384-7213

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Flow Cytometry Requisition

MRN# ( ) PATH#

PATIENT INFORMATION			
Legal Name:		**DOB:**	
Address:			
City:	State:		Zip:
Phone:			

REFERRING CLINICIAN			
Referring Clinician:	**Specialty:**	**NPI:**	
Cell Phone:	**Office:**	**Fax:**	
Group Name:			
Address:			
City:	State:		Zip:

REFERRING INSTITUTION OR PATHOLOGY GROUP			
Institution/Path Group Name:			
Phone:		Fax:	
Address:			
City:	State:		Zip:

SPECIMEN INFORMATION				
SPECIMEN SOURCE:		**COLLECTION DATE:**	**COLLECTION TIME:**	
SPECIMEN TYPE:	☐ **Peripheral Blood**	☐ **Bone Marrow**	☐ **Other, specify source:**	
Required ICD-9 Codes:	**1)**	**2)**	**3)**	**4)**
Pertinent Clinical History and Findings:				
Clinical Differential Diagnosis:				

TEST MENU

☐ **SCREENING PANEL:** Leukemia/Lymphoma/MDS (Additional testing (2-6 antibodies) may be needed if neoplastic cells are present.)

- ☐ Chronic Lymphocytic Leukemia/B-Cell Lymphoma
- ☐ Acute Leukemia/Lymphoblastic Lymphoma
- ☐ T-Cell Lymphoproliferative Disorder/Large Granular Leukemia
- ☐ Plasma Cell Neoplasm Screen
- ☐ CD4 Lymphocytes, Peripheral Blood
- ☐ Lymphocyte Subsets: T, B, and NK Cells
- ☐ Broncho-Alveolar Lavage (CD4:CD8 Ratio)
- ☐ ZAP-70 for CLL only (call for collection instructions)
- ☐ Fetal Hemoglobin
- ☐ B-Cell Lymphoma Staging
- ☐ T-Cell Lymphoma Staging
- ☐ Paroxysmal Nocturnal Hemoglobinuria
- ☐ Sezary Syndrome
- ☐ Immunodeficiency Evaluation*
  - ☐ CBC with Automated Diff- results attached*
  - ☐ CBC with Automated Diff specimen sent for testing *

***For absolute quantitative results when ordering Immunodeficiency Evaluation, a CBC with Automated Differential must also be ordered and a 3.0 ml Lavender top sent *refrigerated* with specimen for flow cytometry testing (transported room temperature) OR results must be sent from CBC with Automated Differential testing done the day before or on the day of shipment.**

BILLING INFORMATION

☐ **Bill Referring Physician/Institution** (MANDATORY, and in accordance with Iowa Law, when the ordering entity is a hospital and the patient has no insurance)
☐ **Bill Patient's Insurance** - If checked and patient has no insurance the referring physician will automatically be billed.

INSURANCE INFORMATION

1) COPY of front/back of patient's insurance card(s). Please designate Primary or Secondary/Tertiary coverage.
2) A PRINTOUT of the patient's demographics and insurance information from your practice management system.

Medicare will only pay for the services that it determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and customary" under the Medicare Standards, Medicare will deny payment for that service or test.