SLUCare Physician Grou

SLUCare PATHOLOGY LABORATORIES

FLOW CYTOMETRY REQUISITION

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PATIENT NAME (LAST, FIRST, MI):		DATE OF BIRTH:	SEX: ☐ M ☐ F	DIAGNOSIS CODE:
DATE OF COLLECTION:	TIME OF COLLECTION: ☐ AM ☐ PM	ACCESSION #:		
PLACE OF SERVICE SPECIMEN WAS OBTAINED: INPATIENT ENTER ADMIT DATE: ____/____/____ ☐ OUTPATIENT ☐ ASC ☐ OFFICE				H #:
REFERRING INSTITUTION:		SPECIMEN TYPE:		
ADDRESS:		CITY:	STATE:	ZIP CODE:
PHONE:	FAX:	REFERRING PHYSICIAN SIGNATURE:		DATE:

AVAILABLE TESTING

- ☐ Flow Cytometry Immunophenotyping (Leukemia/Lymphoma)
- ☐ Hematopathology Consult
- ☐ CD34+ Stem Cell Enumeration
- ☐ T cell Lymph Subset Panel (CD3, CD4, CD8, Ratio)
- ☐ Immune Deficiency Panel
- ☐ Aquired Immune Deficiency Panel
- ☐ Rituximab Therapy Evaluation Panel

ACCEPTABLE SPECIMENS

- ☐ Bone Marrow
  (Sodium Heparin – green tops)
  (EDTA – purple tops)
- ☐ Peripheral Blood
  (Sodium Heparin – green tops)
  (EDTA – purple tops)
- ☐ Body Fluids
  (Sterile container or Sodium Heparin Tubes)
- ☐ Fresh Tissue
  (Kept Cold – NOT FROZEN)
  (Kept Moist with Saline Gauze or in RPMI Fluid)

SPECIAL INSTRUCTIONS / NOTES: