Bone Marrow & Malignancy Requisition

Department of Laboratories
4800 Sand Point Way NE FB.2.441
Seattle, WA 98105 (206) 987-2617
http://seattlechildrenslab.testcatalog.org/

Patient's Last Name	First	Middle	Birth date (required)	Sex

Outside Patient Number	Outside Specimen Number	Send Report To
Ordering Provider		Address
Phone Number	Diagnosis/ICD Code	Phone/Fax

IMPORTANT INFORMATION REGARDING BILLING AND MEDICAL NECESSITY ON BACK

FAX A COPY OF RESULTS TO:
NAME (please print): _____
FAX #: _____

HEALTHCARE PROFESSIONAL TO CALL FOR INFO/ABNORMAL RESULTS:
NAME (please print): _____
PHONE #: _____

REQUIRED SPECIMEN INFORMATION:

DATE COLLECTED: _____/_____/_____

TIME COLLECTED: _____:_____ AM/PM

☐ Bone Marrow Aspirate ☐Right ☐Left ☐Posterior Iliac Crest ☐Other:_____

☐ Bone Marrow Biopsy ☐Right ☐Left ☐Posterior Iliac Crest ☐Other:_____

☐ Peripheral blood ☐ Tissue

DIAGNOSIS

CLINICAL DIAGNOSIS: (Required)

☐Suspected New Leukemia (Clinical Indication):_____

☐Known B ALL ☐Known AML FAB: _____ ☐End of Therapy ☐Suspected Relapse

☐Known T ALL ☐Marrow Failure (MDS) ☐ITP ☐Rule Out MRD

☐Aplastic Anemia ☐Solid Tumor (Indicate Type):_____

☐Other:_____

CHEMOTHERAPY STATUS: (Required)

☐None ☐_____days post_____

☐GCSF:_____ days post ☐Other _____

TYPE OF EXAM

☐**MORPHOLOGY-**Bone Marrow Smears and/or touch preps for pathologist review (1st pull, 0.5-1 mL of Bone Marrow in EDTA-lavender top)

LEUKEMIA/LYMPHOMA IMMUNOPHENOTYPING BY FLOW:

Specimen requirements: 1 Na/Heparin-green top with 1-2 mLs of Bone Marrow; 5 mLs peripheral blood in EDTA also accepted

☐Not Needed
☐Required by Attending Oncologist **(Reason REQUIRED)** →

☐Relapse
☐Marrow contains neoplasia
☐Other: _____

CYTOGENETICS- Neoplasia workup:

Specimen requirements: 2 Na/Heparin-green top with 1-2 mLs Bone Marrow each; 2 mLs peripheral blood in Na/Heparin-green top also accepted

Karyotype
☐Not Needed
☐Required by Attending Oncologist **(Reason REQUIRED)** →

FISH
☐FISH for Applicable Leukemia Panel
☐FISH: MDS Panel
☐FISH for probe:_____

☐Marrow contains neoplasia ☐Marrow Failure
☐Primary tumor not karyotyped ☐Relapse
☐Other: _____

☐Authorize Lab to add/replace exam if indicated

SPECIAL INSTRUCTIONS

For all Molecular studies, please send samples directly to performing laboratory.

Ordering physician, before sending sample, please notify Seattle Children's Pathologist on-call through hospital paging at (206) 987-2000.

Sending laboratory, please contact Seattle Children's Main Laboratory at (206) 987-2617 with method of transport and shipping number.

BILLING INFORMATION

PHYSICIAN NOTIFICATION: Only tests that you believe are appropriate for patient care should be ordered. Medicare/Medicaid will pay only for tests that are medically necessary for the diagnosis and treatment of the patient, rather than for screening purposes.

BILLING NOTIFICATION: All samples will be billed to the referring institution unless complete billing and diagnosis information is provided on this form. Contact Seattle Children's Laboratory Client Services for additional assistance (206) 987-2617.

BILL TO:

☐ **Referring Institution (Preferred)** - Provide billing address or stamp institution's information.
(Institutional billing will be done for all patients with Medicare except for established Seattle Children's patients.)

Billing Address:	Billing Contact Name:
Billing Contact Phone/Fax:	Billing Contact Email:

☐ **Primary Insurance** (Attach copy of card.) ☐ **Medicaid** (Only Alaska, Idaho, Montana and Washington Medicaid are accepted.)

Patient Address		
Guarantor Name	DOB	Relationship to Patient
Guarantor Address (if different from patient's)		
Guarantor Phone (if different from patient's)		Employer
Primary Care Physician		Phone Number
Insurance Company/Medical Coverage		
Claims Address		Phone Number
Policy Number		Group Number
Subscriber	Sex	Subscriber's DOB

☐ **Secondary Insurance** (Attach copy of card.) ☐ **Medicaid** (Only Alaska, Idaho, Montana and Washington Medicaid are accepted.)

Insurance Company/Medical Coverage		
Claims Address		Phone Number
Policy Number		Group Number
Subscriber	Sex	Subscriber's DOB

☐ **Self Pay**- First, call Lab Client Services for pricing. Then, provide credit card information below or enclose a check with the sample.

Patient Address		
Guarantor Name	DOB	Relationship to Patient
Guarantor Address (if different from patient's)		
Guarantor Phone (if different from patient's)		
Name on Credit Card	Payment Amount	CVN
Card Number	Card Type	Expiration

Please visit our test catalog at http://seattlechildrenslab.testcatalog.org for testing information or call (206) 987-2617.

Seattle Children's®
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Ship to: Lab Client Services
4800 Sand Point Way NE, M/S: FB.2.441
SEATTLE, WA 98105