City of Hope | LABORATORIES

ROUTINE REQUISITION

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SEND TO:	City of Hope National Medical Center - ATTENTION: LAB OUTREACH DEPT 1500 E. Duarte Road Main Medical Room 2101, Duarte, CA 91010 TOLL FREE: 1(844) 313-5227 (LABS) FAX: (626) 218-0736 EMAIL: laboutreach@coh.org

INSTRUCTIONS: USE CONSULTATION KITS PROVIDED BY CITY OF HOPE OR CALL (626) 218-0100

SUBSPECIALTY:	CITY OF HOPE PATHOLOGIST:	**Form Completed By:** **Phone/Extension:**

INSTITUTION / FACILITY NAME:

Name: _____
Address: _____
City, State, Zip Code: _____
Tel: _____ Fax: _____

PLEASE SELECT ORDERING MD BOX BELOW:

Ordering MD: _____

NPI#_____

PATIENT INFO:

PATIENT INFORMATION IN THIS SECTION IS MANDITORY, MISSING INFORMATION MAY DELAY REVIEW OF CASE

PATIENT LAST NAME: **FIRST NAME:**

ADDRESS:

CITY **STATE** **ZIP CODE**

AGE: **DOB:**

SEX (CIRCLE ONE): ◯ *M* ◯ *F*

MARITAL STATUS:

BILL TO:

☐ **SEE ATTACHED:** INSURANCE CARD (front and back) and PATIENT DEMOGRAPHICS

- ☐ **Institution / Client**
- ☐ **Patient (Self Pay)**
- ☐ **PPO**
- ☐ **Medicare**
- ☐ **Other Insurance**
- ☐ **MediCal / Medicaid**
- ☐ **HMO** _____

***** Authorization Number Required*****

CLINICAL INFORMATION (Suspect diagnosis, Pertinent Lab Data):

ICD-10 CODES

SITE OF LESION: **SOURCE:** **SPECIMEN ID:**

COLLECTION DATE: **COLLECTED TIME:**

SERVICES REQUESTED

PROFESSIONAL CONSULTATION

- ☐ **PROFESSIONAL CONSULT** (SLIDES ONLY)
- ☐ **PROFESSIONAL CONSULT WITH IHC (SLIDES & BLOCKS)** Call for approval of special testing
- ☐ **COMPREHENSIVE CONSULTATION (SLIDES & BLOCKS)** IHC & special testing at discretion of consultant

IMMUNOHISTOCHEMISTRY (IHC)

- ☐ IHC with Professional Interpretation
  Specify Desired Antibodies: _____
- ☐ IHC Staining Only
  Specify Desired Antibodies: _____

CYTOGENETICS (WBC)

- ☐ Standard Cytogenetics
- ☐ FISH *(Must Specify Probe)*
- ☐ Other

FLOW CYTOMETRY (SPECIFY):

- ☐ Leukemia
- ☐ Lymphoma
- ☐ Myeloma
- ☐ PNH
- ☐ T-cell Subsets
- ☐ Other

MOLECULAR DIAGNOSTICS

DNA source/concentration (accepted only if isolated by CLIA-certified or equivalent lab):

Specify Request:

OTHER TESTING:

SPECIMEN TYPE:

- #:_____ FRESH TISSUE
- #:_____ FIXED TISSUE
- #:_____ FROZEN TISSUE
- #:_____ LYMPH NODE
- #:_____ BLOOD
- #:_____ BONE MARROW
- #:_____ CBC WITH DIFFERENTIAL
- #:_____ PARAFFIN BLOCK
- #:_____ SLIDES

City of Hope National Medical Center relies upon the accuracy of the above information as provided by Institution in the rendering of services under the Agreement. Institution will provide prompt written notification of any changes to City of Hope.