ALBANY MEDICAL CENTER DEPARTMENT
OF PATHOLOGY AND LABORATORY
MEDICINE
CELLULAR IMMUNOLOGY
43 NEW SCOTLAND AVENUE
ALBANY, NEW YORK 12208
PH: (518) 262-5367, 5657
FAX: (518) 262-5048

Hospital or Physician Office Name:

AFFIX ARRIVAL LABEL OR COMPLETE BELOW:

NAME: DOB: SEX:

ADDRESS:

SS#: PHYSICIAN:

PRIMARY INSURANCE CO.: (Note: if from hospital- bill hospital as primary)

PHLEBOTOMIST INITIALS | DATE COLLECTED | TIME COLLECTED

PHYSICIAN SIGNATURE: COPY TO:

SECONDARY INSURANCE CO: USE PATIENT'S PRIVATE INSURANCE

		DIAGNOSIS / ICD10 CODES MANDATORY FOR EACH TEST ORDERED		
STAT				
PHONE		1.	2.	3.
FAX		4.	5.	6.

SUBSCRIBER: PLAN NAME:

RELATIONSHIP TO SUBSCRIBER: DOB: SEX:

ID#: GROUP #:

NOTIFICATION TO PHYSICIANS AND OTHER PERSONS LEGALLY AUTHORIZED TO ORDER TESTS FOR WHICH MEDICARE REIMBURSEMENT WILL BE SOUGHT:
MEDICARE WILL ONLY PAY FOR TESTS THAT MEET THE MEDICARE COVERAGE CRITERIA AND ARE REASONABLE AND NECESSARY TO TREAT OR DIAGNOSE AN INDIVIDUAL PATIENT. MEDICARE DOES NOT PAY FOR TESTS FOR WHICH DOCUMENTATION, INCLUDING THE MEDICAL RECORD, DOES NOT SUPPORT THAT THE TESTS WERE REASONABLE AND NECESSARY. MEDICARE GENERALLY DOES NOT COVER ROUTINE SCREENING TESTS EVEN IF THE PHYSICIAN OR OTHER AUTHORIZED PRACTITIONER CONSIDERS THE TESTS APPROPRIATE FOR THE PATIENT.

FLOW CYTOMETRY REQUEST FORM

PLEASE COMPLETE ALL INFORMATION:

SPECIMEN TYPE: _____

COLLECTION DATE: _____

COLLECTION TIME: _____

DIAGNOSIS: _____

REQUESTING PHYSICIAN: _____

HISTORY: _____

_____

Flow Cytometry Panels for Flow Cytometry Testing (Please Call Flow Lab at 262-5367 or 5657 before sending specimen)

BLP	☐ B-Cell Lymphoma/CLL	(CD10,23,19,HLA DR,CD7,3/ CD5,38,20,CD2,4,8,FMC7,22,sKappa / sLambda & CD45)
TLP	☐ T-Cell Lymphoma	(CD 10,23,19/ HLA DR,CD7,3/ CD5,38,20/ CD2,4,8/ TCRa/b, TCRg/d,CD57,CD16/56 &CD45)
MYP	☐ Myeloma	(CD10,23,19/ HLA DR,CD7,3/ CD5,38,20,FMC7,CD22/138,56/ cyKappa / cyLambda &CD45)
HCLPCI	☐ Hairy Cell Leukemia	(CD10,23,19/ HLA DR,CD7,3/ CD5,38,20/ FMC7,CD25,CD103,11c, sKappa / sLambda & CD45)
ALP	☐ Acute Leukemia	(CD10,117,19/ HLA DR,CD7,3/ CD5,22,20/ CD33,13,34/ CD14,11b,4/ TdT, MPO & CD45)
	☐ OTHER (list individual markers)	_____

The following tests can only be performed on peripheral blood specimens:

TCS2	☐ T-CELL SUBSET	(Includes CD3, CD4, CD8 & CD45)	1- LAV
TBCS2	☐ T & B-CELL SUBSET	(Includes CD3,CD4,CD8,CD19 & CD45)	1- LAV
TBNKC2	☐ T,B & NK-CELL SUBSET	(Includes CD3 ,CD4, CD8, CD19,CD16/56 &CD45)	1-LAV
PNHFLR	☐ PAROXYSMAL NOCTURNAL HEMOGLOBINURIA	(Includes CD14, CD33, CD45, CD59, CD235a & FLAER)	1- LAV

(rev 10/18)