ALBANY MEDICAL CENTER HOSPITAL
DEPT OF PATHOLOGY&LAB MEDICINE
CELLULAR IMMUNOLOGY LABORATORY

43 NEW SCOTLAND AVENUE
ALBANY, NEW YORK 12208
PH: (518) 262-5367
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 (additional reflex testing will be performed if necessary):

LEUKEMIA-LYMPHOMA IMMUNOPHENOTYPING

- BLPN ☐ **MATURE B CELL NEOPLASM**
- TLPN ☐ **MATURE T/NK CELL NEOPLASM**
- MYPN ☐ **PLASMA CELL NEOPLASM / MULTIPLE MYELOMA**
- HCLPN ☐ **HAIRY CELL LEUKEMIA**
- ALPN ☐ **ACUTE LEUKEMIA** - circle if known: AML B-ALL T-ALL
- ☐ **OTHER (specify)** _____

LYMPHOCYTE SUBSETS

- TCS2 ☐ **T CELL SUBSET** (CD3, CD4, CD8, CD45)
- TBCS2 ☐ **T & B CELL SUBSET** (CD3, CD4, CD8, CD19, CD45)
- TBNKC2 ☐ **T, B & NK CELL SUBSET** (CD3 ,CD4, CD8, CD19, CD16/CD56, CD45)

hsPNH

- hsPNH ☐ **HIGH SENSITIVITY PNH** (PAROXYSMAL NOCTURNAL HEMOGLOBINURIA)

Specimen requirements

LEUKEMIA-LYMPHOMA: peripheral blood: 1 lavender top tube
fresh tissue: place in Cellular Immunology Lab Transport media or sterile saline
bone marrow: 1 green top tube (preferred), red top tube from heparinized syringe or lavender top tube

LYMPHOCYTE SUBSETS: peripheral blood: 1 lavender top tube

hsPNH: peripheral blood: 1 lavender top tube

(rev 01/26)