



Clinical Molecular and Genomic Pathology

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Hematologic Malignancy Test Requisition Form

Patient Information

First Name: _____ Last Name: _____
Address: _____

Phone: _____
MR#: _____
DOB (MM/DD/YYYY): _____
Gender: Male Female

Clinical Information

Diagnosis (Required): _____

Sample Information

Peripheral Blood Bone Marrow
Collection Date/Time: _____
Collector: _____

Test Requested

- Hematologic Malignancy Panel (94 Genes)
- FLT3-ITD
- FLT3-TKD
- NPM1
- CEBPA

Referring Physician

Name: _____
Address: _____

Phone: _____ Fax: _____
Email: _____
Requesting Physician/Genetic Counselor/Other Contact Name:

Phone: _____ Email: _____
Referring Physician Signature (Required):

Billing Information

- Medicaid/Medicare
- Commercial Insurance
Pre-Authorization (Required): _____
- Patient Responsibility

Note:

- > Provide all billing related information.
- > For commercial insurance, preapproval required. Test will not be performed until preapproval is obtained.
- > For Medicaid/Medicare, medical necessity MUST be provided.

Official Use Only

Received by: _____
Comments: _____

