



Add-On Test Authorization - Hematopathology

Fax: 206-215-5935 or 866-721-9696

Patient's insurance information required for add-on testing

Patient's Name: _____ CellNetix Accession #/Consult Accessions: _____

Patient's Date of Birth: _____ Original CellNetix Date of Service: _____

Ordering Physician and Facility _____ ICD10: _____

Specimen Information

- Bone Marrow Aspirate
- Bone Marrow Biopsy
- Paraffin Block
- Peritoneal Fluid
- Pleural Fluid
- Peripheral Blood
- CSF (Transport ASAP at 2-8° C)
- FNA (Transport ASAP at room temperature)
- Fresh Tissue Biopsy
- Specimen Type: _____
- Media Type: _____
- Other _____

Disease State

- Presentation
- Known Diagnosis _____
- MRD/Post Therapy (Days post Rx _____)
- Recurrence

Clinical Information

Tissue Specimens for Histology

Time in Formalin _____
 A _____
 B _____
 C _____
 D _____

PLEASE PRINT CLEARLY

Molecular Studies

- | | |
|--|---|
| <input type="checkbox"/> BCR-ABL1 Screen (p210+p190), Quant RT-PCR | <input type="checkbox"/> FLT3-ITD and NPM1 and CEBPA by PCR |
| <input type="checkbox"/> BCR-ABL1 p210 Quant RT-PCR | <input type="checkbox"/> FLT3-ITD and NPM1 by PCR |
| <input type="checkbox"/> BCR-ABL1 p190 Quant RT-PCR | <input type="checkbox"/> FLT3-ITD (semi-quant) by PCR |
| <input type="checkbox"/> JAK2_V617F by PCR | <input type="checkbox"/> NPM1 (semi-quant) by PCR |
| <input type="checkbox"/> CALR Ex9 indels by PCR | <input type="checkbox"/> CEBPA by PCR |
| <input type="checkbox"/> MPL_W515K/L by PCR | <input type="checkbox"/> CEBPA by sequencing |
| <input type="checkbox"/> JAK2_V617F and CALR and MPL | <input type="checkbox"/> IDH1/2 sequencing |
| <input type="checkbox"/> JAK2_V617F ref to CALR / MPL | <input type="checkbox"/> KIT sequencing |
| <input type="checkbox"/> JAK2_V617F ref to CALR / MPL / JAK2_Ex12-16 | <input type="checkbox"/> TP53 sequencing |
| <input type="checkbox"/> JAK2_V617F ref to Ex12-16 | <input type="checkbox"/> BRAF for HCL and LCH by PCR |
| <input type="checkbox"/> JAK2_Ex12-16 sequencing | |

Next Generation Sequencing

- NGS_Myeloid Hotspot Panel (37 genes for AML, MPN, MDS, CMML)

Flow Cytometry

- | | |
|--|---|
| <input type="checkbox"/> Mature B, T, & NK Cell Neoplasms | <input type="checkbox"/> Acute Myeloid Leukemia (AML) & Related Precursor Neoplasms |
| <input type="checkbox"/> Precursor Lymphoid Neoplasms (B-ALL, T-ALL) | <input type="checkbox"/> Myeloproliferative Neoplasms/Myelodysplastic Syndromes |
| <input type="checkbox"/> Plasma Cell Panel | <input type="checkbox"/> Paroxysmal Nocturnal Hemoglobinuria (PNH) Panel |
| <input type="checkbox"/> Mastocytosis | |

FISH

- Chronic Lymphocytic Leukemia (CLL) Panel
- Multiple Myeloma (MM) Panel

Other: _____

REQUIRED - Physician or authorized designee signature

PRINT NAME

For CellNetix Use Only-

Date Received:

SSS Initials:

Pathologist Initials: