

**Required Information is Highlighted**

**CellNetix Pathology & Laboratories**



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01-07-2022

Patient Information				Specimen Information		
PATIENT LAST NAME	FIRST	M.I.	BIRTH SEX <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> X	GENDER ID <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> X	COLLECTION DATE	TIME
PATIENT D.O.B.	PATIENT SOCIAL SECURITY NUMBER	PHONE	RACE/ETHNICITY		ICD-10 CODE(S)	
STREET ADDRESS				Referring MDs		
CITY	STATE	ZIP				
Billing Information				CC report to: <b>First and Last Names</b>		
INSURANCE COMPANY NAME AND ADDRESS						
CITY	STATE	ZIP				
INSURANCE/SUBSCRIBER ID#	SUBSCRIBER NAME/RESPONSIBLE PARTY					
INSURANCE/GROUP#	MEDICARE#	<input type="checkbox"/> PRIMARY <input type="checkbox"/> SECONDARY				
SECONDARY	MEDICAID (coupon attached)					
<input type="checkbox"/> NO INSURANCE	WORKER'S COMP	<input type="checkbox"/> YES <input type="checkbox"/> NO				
INTERNAL USE ONLY						

HEMATOPATHOLOGY		
<b>SPECIMEN INFORMATION</b> <input type="checkbox"/> Bone Marrow Aspirate <input type="checkbox"/> CSF (Transport ASAP at 2-8°C) <input type="checkbox"/> Bone Marrow Biopsy <i>Any sample suspected of having prior disease will not be accepted.</i> <input type="checkbox"/> Paraffin Block <input type="checkbox"/> Peritoneal Fluid <input type="checkbox"/> FNA (Transport ASAP at room temperature) <input type="checkbox"/> Pleural Fluid <input type="checkbox"/> Fresh Tissue Biopsy <input type="checkbox"/> Peripheral Blood    Specimen Type: _____ <input type="checkbox"/> Other    Media type: _____	<b>DISEASE STATE</b> <input type="checkbox"/> Presentation <input type="checkbox"/> Known Diagnosis _____ <input type="checkbox"/> MRD/Post Therapy (Days post Rx _____) <input type="checkbox"/> Recurrence	<b>TISSUE SPECIMENS FOR HISTOLOGY</b> Time in Formalin _____ A _____ B _____ C _____ D _____
<b>Molecular Genetics</b>		
<input type="checkbox"/> BCR-ABL1 Screen (p210+p190), Quant RT-PCR <input type="checkbox"/> BCR-ABL1 p210 Quant RT-PCR <input type="checkbox"/> BCR-ABL1 p190 Quant RT-PCR <input type="checkbox"/> JAK2_V617F by PCR <input type="checkbox"/> CALR Ex9 indels by PCR <input type="checkbox"/> MPL_W515K/L by PCR <input type="checkbox"/> JAK2_V617F and CALR and MPL <input type="checkbox"/> JAK2_V617F ref to CALR / MPL <input type="checkbox"/> JAK2_V617F ref to CALR / MPL / JAK2_Ex12-16 <input type="checkbox"/> JAK2_V617F ref to Ex12-16 <input type="checkbox"/> JAK2_Ex12-16 sequencing		
<input type="checkbox"/> FLT3-ITD and NPM1 and CEBPA by PCR <input type="checkbox"/> FLT3-ITD and NPM1 by PCR <input type="checkbox"/> FLT3-ITD (semi-quant) by PCR <input type="checkbox"/> NPM1 (semi-quant) by PCR <input type="checkbox"/> CEBPA by PCR <input type="checkbox"/> CEBPA by sequencing <input type="checkbox"/> IDH1/2 sequencing <input type="checkbox"/> KIT sequencing <input type="checkbox"/> TP53 sequencing <input type="checkbox"/> BRAF for HCL and LCH by PCR		
<b>Next Generation Sequencing</b>		
<input type="checkbox"/> NGS_Myeloid Hotspot Panel (37 genes for AML, MPN, MDS, CMML)		
<b>Flow Cytometry</b>		
<input type="checkbox"/> CellNetix Pathologist to select testing deemed necessary to provide comprehensive analysis and professional interpretation on referred material. <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		
<b>FISH</b>		
<input type="checkbox"/> Chronic Lymphocytic Leukemia (CLL) Panel <input type="checkbox"/> Multiple Myeloma (MM) Panel <input type="checkbox"/> Other _____		