



Add-On Test Authorization - Hematopathology

Fax: 206-215-5946 or Email: allsendouts@cellnetix.com

Date of Request: _____

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: _____

Collection Date: _____ Collection Time: _____

Ordering Physician: _____ Ordering Facility: _____

Ordering Physician Phone: _____ ICD10: _____

Specimen Information

- Bone Marrow Aspirate
- Bone Marrow Biopsy
- Paraffin Block
- Peritoneal Fluid
- Pleural Fluid
- Peripheral Blood
- Other _____
- CSF (Transport ASAP at 2-8 C)
Any sample suspected of having prion disease will not be accepted.
- FNA (Transport ASAP at room temperature)
- Fresh Tissue Biopsy
Specimen Type: _____
Media Type: _____

Clinical Information

Tissue Specimens for Histology

Time in Formalin _____

A _____

B _____

C _____

D _____

Disease State

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

PLEASE PRINT CLEARLY

MOLECULAR STUDIES

- BCR-ABL1 Screen (p210+p190), Quant RT-PCR
- BCR-ABL1 p210 Quant RT-PCR
- BCR-ABL1 p190 Quant RT-PCR
- JAK2_V617F by PCR
- CALR Ex9 indels by PCR
- MPL_W515K/L by PCR
- JAK2_V617F ref to CALR / MPL
- JAK2_Ex12-16 sequencing
- FLT3-ITD/TKD and NPM1 by PCR
- FLT3-ITD and NPM1 by PCR
- FLT3-ITD by PCR
- FLT3-TKD by PCR
- NPM1 by PCR
- NPM1 MRD by sequencing
- IDH1/2 sequencing
- KIT sequencing
- TP53 sequencing
- BRAF for HCL and LCH by PCR
- MYD88_L265P by PCR
- CXCR4 by sequencing

NEXT GENERATION SEQUENCING

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

FLOW CYTOMETRY

- Mature B, T, & NK Cell Neoplasms
- Precursor Lymphoid Neoplasms (B-ALL, T-ALL)
- Plasma Cell Panel
- Mastocytosis
- Acute Myeloid Leukemia (AML) & Related Precursor Neoplasms
- Myeloproliferative Neoplasms/Myelodysplastic Syndromes
- Paroxysmal Nocturnal Hemoglobinuria (PNH) Panel

FISH

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

OTHER: _____

REQUIRED - Physician or authorized designee signature

DATE

TIME

PRINT NAME

For CellNetix Use Only-

Date Received:

SSS Initials:

Pathologist Initials: