Roswell Park Cancer Institute
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TESTING REQUISITION

Date & Time Drawn ___/___ / ___
___/___ AM/PM

NYS Laboratory Permit #: 43041401M220
CLIA #: 33D0171366
PK Wallace State certification code: WALLP1

CLIENT IDENTIFICATION / *PATIENT*

Last Name	First Name		MI
Address	City	St	Zip Code
DOB	Age	Gender: M/F	Patient ID#
Ordering Physician		MRN	
Treating Physician			

FLOW CYTOMETRIC TEST REQUEST

Date Obtained	**Time**
Specimen Type	☐ Bone Marrow Aspirate ☐ Bone Marrow Core ☐ Peripheral Blood ☐ Other: ________________

Clinical Diagnosis

IMPORTANT: Please provide clinical information (check boxes below) and a copy of

☐ Aplastic anemia (AA)	☐ Lymphoma	☐ Post Transplant
☐ Leukemia	☐ Newly Diagnosed	☐ Unexplained Cytopenia
☐ Myelodysplastic Sydrome (MDS)	☐ Known PNH	☐ Other _______

Select one of the following

☐ Leukemia screen	☐ T-lymhoproliferative	☐ CD34 Count	☐ DNA index/ cell cycle
☐ Lymphoma/ ALL/CLL	☐ CD4/CD8 screen	☐ PNH (Blood only)	☐ Other
☐ AML/CML/MDS	☐ Multiple myeloma	☐ Normal donor	

Shipping Instructions

Blood and bone marrow specimens should be drawn into sodium heparin (green top) tubes. We would prefer 1 tube (approximately 6 ml) per patient time point, however, assuming an adequate WBC count 3 mL is a minimum volume. Samples must be labeled with two forms of ID such as patient name, and medical record number, date and time drawn must also be indicated. They should be shipped at ambient temperature. Samples and the completed test request form should be sent to tube station 621. Samples from outside of Roswell should be shipped to the address above via FedEx using standard next day service or if collected on a Friday clearly marked for Saturday delivery. For tissue samples please mince into small 1-5 mm pieces, and place into a small securely capped tube with RPMI or comparable tissue culture media. For additional questions please contact the lab at (716) 845-3528.

Test Requested by:	**For Lab Use Only**
Signature:	Date Received Time
Requesters mailing address, include contact information and instructions for reporting result Street ____________________	Lab ID #
City ____________ Zip ________ ☐ FAX: __________ ☐ EMAIL: __________	Comments