

Client Information			Billing Information (Attach face sheet & front and back of Insurance Card)		
Client:			Bill: <input type="checkbox"/> Insurance <input type="checkbox"/> Medicare - Part B <input type="checkbox"/> Patient <input type="checkbox"/> Hospital/Institution		
Address:			Patient Status: <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Non-Hospital patient		
			Pre-Authorization #		
			Healthplan <input type="checkbox"/> See attached billing info		
			Address		
Ordering Physician		UPIN #	NPI#		Policy / Cert. #
Phone ()		Fax ()			Group / Plan #
				Medical Group	
Treating Physician		UPIN #	NPI#		Name of Insured
Phone ()		Fax ()			Ins. Phone ()
				Relationship to Insured	
				Secondary Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, please attach)	
				Medicare will only reimburse for tests which meet Medicare coverage criteria and are reasonable and necessary to treat or diagnose an individual patient.	

Patient Information		
Name (Last, First)	Social Security #	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female D.O.B.
Address	Med. Rec. No. / Patient No.	Phone ()

Specimen Information (Required)	
<input type="checkbox"/> Bone Marrow Biopsy: Core _____ Clot _____ Must Provide CBC and Pathology Report	Diagnosis or Signs/Symptoms (ICD-9 or Narrative): _____
<input type="checkbox"/> Bone Marrow Biopsy Aspirate: Green top(s) _____ Purple top(s) _____ <input type="checkbox"/> Other _____	Collection Date & Time _____
<input type="checkbox"/> Peripheral Blood: Green top(s) _____ Purple top(s) _____ <input type="checkbox"/> Other _____	Body Site _____
<input type="checkbox"/> Smears: _____ Air dried _____ Stained (type of stain) _____	Specimen ID # (s) _____
<input type="checkbox"/> Fluids: CSF _____ Pleural _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> Test Bone Marrow - use blood as back-up <input type="checkbox"/> Test All Tubes
<input type="checkbox"/> Fresh Tissue either <input type="checkbox"/> Tumor or <input type="checkbox"/> Lymph node (required)	
<input type="checkbox"/> FFPE Tissue: Block(s) _____ Unstained Slides _____ <input type="checkbox"/> Other _____	

Clinical Information	
Clinical History _____	Lymphoproliferative Disorders
<input type="checkbox"/> New Diagnosis <input type="checkbox"/> Staging <input type="checkbox"/> Minimal Residual Disease <input type="checkbox"/> Monitoring	<input type="checkbox"/> Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL) <input type="checkbox"/> Mantle cell lymphoma (MCL)
THERAPY <input type="checkbox"/> Current (type) _____ <input type="checkbox"/> Prior (>1 month ago)	<input type="checkbox"/> Follicular lymphoma (FL) <input type="checkbox"/> Hairy cell leukemia (HCL) <input type="checkbox"/> Diffuse large B-cell lymphoma (DLBCL)
<input type="checkbox"/> Rituxan® <input type="checkbox"/> Campath® <input type="checkbox"/> Gleevec® <input type="checkbox"/> Mylotarg® <input type="checkbox"/> Velcade® <input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Burkitt lymphoma <input type="checkbox"/> Hodgkin lymphoma <input type="checkbox"/> Marginal zone lymphoma <input type="checkbox"/> T-cell lymphoma
<input type="checkbox"/> Radiotherapy <input type="checkbox"/> EPO <input type="checkbox"/> GCSF <input type="checkbox"/> GM-CSF <input type="checkbox"/> Other _____	Myeloproliferative Neoplasms
<input type="checkbox"/> Bone Marrow Transplant Type: <input type="checkbox"/> Autologous <input type="checkbox"/> Allogeneic <input type="checkbox"/> Sex Mismatch	<input type="checkbox"/> CML <input type="checkbox"/> Polycythemia vera (PV) <input type="checkbox"/> Essential thrombocytosis (ET)
Gender of the Donor Required <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Primary Myelofibrosis (PMF) <input type="checkbox"/> Other _____
	Plasma Cell Neoplasms
	<input type="checkbox"/> Multiple Myeloma (MM)
	<input type="checkbox"/> Plasma Cell Dyscrasia
	Myelodysplastic Syndrome (MDS) <input type="checkbox"/> MDS <input type="checkbox"/> CMML <input type="checkbox"/> Other _____
	Acute Leukemias <input type="checkbox"/> AML <input type="checkbox"/> APL <input type="checkbox"/> ALL <input type="checkbox"/> Anemia <input type="checkbox"/> Pancytopenia <input type="checkbox"/> Other _____

■ COMPREHENSIVE CONSULTATION ONE-STEP HEMATOPATHOLOGY EVALUATION†
†Based upon their judgment, Clarient hematopathologists will select clinically indicated tests.

INDIVIDUAL TEST ANALYSIS		
Only perform testing on the submitted specimen(s) using the specific individual test components listed below. An interpretation report is not a component of "Technical Only" testing.		
FLOW CYTOMETRY	BONE MARROW MORPHOLOGY	FLUORESCENCE IN SITU HYBRIDIZATION (FISH)
Global Flow Panels	CHROMOSOME ANALYSIS	<input type="checkbox"/> APL Panel
<input type="checkbox"/> Myeloid, B-&T-Cell (Comprehensive)	<input type="checkbox"/> Classical Cytogenetics <input type="checkbox"/> Array-CGH	<input type="checkbox"/> CML
<input type="checkbox"/> B-&T-Cell <input type="checkbox"/> Plasma Cell	(Clinical indication required)	<input type="checkbox"/> BCR/ABL1, t(9;22)
<input type="checkbox"/> PNH, High Sensitivity, FLAER, EDTA	POLYMERASE CHAIN REACTION (PCR)	<input type="checkbox"/> ALL Panel
Peripheral Blood Only (Additional tests will be ordered if medically necessary)	<input type="checkbox"/> Quantitative BCR/ABL, t(9;22) Major (p210) & Minor (p190) for CML & ALL	<input type="checkbox"/> BCR/ABL1, t(9;22)
Technical-Only Flow Panels	<input type="checkbox"/> Quantitative BCR/ABL, t(9;22) Major (p210) for CML	<input type="checkbox"/> MLL Rearrangement (11q23)
<input type="checkbox"/> Myeloid, B-&T-Cell (Comprehensive)	<input type="checkbox"/> Quantitative BCR/ABL, t(9;22) Minor (p190) for ALL	<input type="checkbox"/> MLL Rearrangement (11q23)
<input type="checkbox"/> Hairy Cell Leukemia <input type="checkbox"/> Hematogone	<input type="checkbox"/> ABL Kinase Mutation (Gleevec® resistance)	<input type="checkbox"/> CLL/SLL Panel
<input type="checkbox"/> T-Cell Receptor <input type="checkbox"/> NK/T Cell	<input type="checkbox"/> PML/RARA, t(15;17) for APL monitoring	<input type="checkbox"/> 11q deletion (ATM)
<input type="checkbox"/> CD5 <input type="checkbox"/> CD10 <input type="checkbox"/> B- & T-Cell	<input type="checkbox"/> JAK2 V617F Mutation Analysis for non-CML MPN	<input type="checkbox"/> 13q deletion (D13S319)
<input type="checkbox"/> PNH, High Sensitivity, FLAER, EDTA	<input type="checkbox"/> JAK2 Exon 12 Mutation Analysis for non-CML MPN	<input type="checkbox"/> 17p deletion (TP53)
Peripheral Blood Only (Additional tests will be ordered if medically necessary)	<input type="checkbox"/> MPL Mutation Analysis non-CML MPN	<input type="checkbox"/> Trisomy 12 (+12)
<input type="checkbox"/> Plasma Cell <input type="checkbox"/> ZAP-70 <input type="checkbox"/> Erythroid	<input type="checkbox"/> B-Cell Gene Rearrangement (B-Cell Clonality)	<input type="checkbox"/> Plasma Cell/Myeloma Panel
<input type="checkbox"/> B-ALL <input type="checkbox"/> T-ALL <input type="checkbox"/> Lineage	<input type="checkbox"/> T-Cell Gene Rearrangement (T-Cell Clonality)	<input type="checkbox"/> 13q deletion (D13S319)
<input type="checkbox"/> Megakaryocytes <input type="checkbox"/> CLL/SLL	<input type="checkbox"/> FLT3 ITD/DB35 Mutation Analysis for AML	<input type="checkbox"/> 17p deletion (TP53)
<input type="checkbox"/> Cytoplasmic Light Chain (Kappa)	<input type="checkbox"/> NPM1 Mutation Analysis for AML	<input type="checkbox"/> IGH/CCND1, t(11;14)
<input type="checkbox"/> Cytoplasmic Light Chain (Lambda)	<input type="checkbox"/> CEBPA Mutation Analysis for AML	<input type="checkbox"/> IGH/FGFR3, t(4;14)
	<input type="checkbox"/> KIT D816V Mutation Analysis for AML	<input type="checkbox"/> IGH/MAF, t(14;16) OPTIONAL
		<input type="checkbox"/> ALK Rearrangement (2p23)
		<input type="checkbox"/> IGH/BCCL2, t(11;14)
		<input type="checkbox"/> BCL2 Rearrangement (18q21)
		<input type="checkbox"/> BCL6 Rearrangement (3q27)
		<input type="checkbox"/> IGH/MYC, t(8;14)
		<input type="checkbox"/> MYC Rearrangement (8q24)
		<input type="checkbox"/> DLBCL Panel
		<input type="checkbox"/> 11q deletion (ATM)
		<input type="checkbox"/> BCL6 Rearrangement (3q27)
		<input type="checkbox"/> IGH/BCCL2, t(11;14)
		<input type="checkbox"/> BCL2 Rearrangement (18q21)
		<input type="checkbox"/> IGH/MAF, t(14;16) OPTIONAL
		<input type="checkbox"/> MYC Rearrangement (8q24)
		<input type="checkbox"/> ALK Rearrangement (2p23)
		<input type="checkbox"/> MALT Rearrangement (18q21)
		<input type="checkbox"/> X/Y for Bone Marrow Transplant
		<input type="checkbox"/> Other _____
Authorized Signature:	Date:	Client Use Only:
		<input type="checkbox"/> N/A <input type="checkbox"/> Path Rep <input type="checkbox"/> Slides _____
		<input type="checkbox"/> Insurance <input type="checkbox"/> Tubes _____ <input type="checkbox"/> Container _____ <input type="checkbox"/> Smears _____

Clariant Panel Descriptions

DISEASE-STATE WORKUPS

Acute Lymphoid Leukemia (ALL)

Flow Cytometry
Cytogenetics
FISH
MLL Rearrangement (11q23)
BCR/ABL, t(9;22)

Acute Myeloid Leukemia

Flow Cytometry
Cytogenetics
FISH
RUNX1/RUNX1T1 (AML/ETO) t(8;21)
PML/RARA t(15;17)
CBFB, inv(16), t(16;16)
MLL Rearrangement (11q23)
PCR (for prognosis)
FLT3 ITD/D835 Mutation Analysis
NPM1 Mutation Analysis
CEBPA Mutation Analysis
KIT D816V Mutation Analysis

Chronic Lymphoid Leukemia (CLL)

Flow Cytometry
Array-CGH
FISH
11q deletion (ATM)
Trisomy 12 (+12)
13q deletion (D13S319)
17p deletion (TP53)
t(11;14) to exclude MCL
IHC (If needed to confirm diagnosis)

Chronic Myeloid Leukemia (CML)

Flow Cytometry
Cytogenetics
FISH
BCR/ABL, t(9;22)
PCR (If needed for MRD or to confirm diagnosis)
Quantitative BCR/ABL, t(9;22)

Myelodysplastic Syndromes (MDS)

Flow Cytometry
Cytogenetics
A-CGH
FISH
5q deletion (5q33-34)
7q deletion (7q31)
Trisomy 8 (+8)
20q deletion (20q12)

Myeloproliferative Neoplasms (MPN) other than CML

Flow Cytometry
Cytogenetics
FISH: t(9;22) to R/O CML
PCR
JAK2 V617F & Exon 12 Mutation Analysis
MPL Mutation Analysis

Hodgkin Disease/Hodgkin Lymphoma

Cytogenetics
IHC: CD15, CD30, CD45, EBV
ISH: EBER

Plasma Cell Myeloma/Multiple Myeloma (MM)

Flow Cytometry
Cytogenetics/A-CGH
FISH
IGH/CCND1, t(11;14)
IGH/FGFR3, t(4;14)
13q deletion (D13S319)
17p deletion (TP53)
IGH/MAF, t(14;16) {optional}
IHC: IHC for CD138 on core biopsy

Non-Hodgkin Lymphoma (NHL)

Flow Cytometry
Cytogenetics
FISH
IGH/CCND1, t(11;14)
MYC Rearrangement (8q24)
BCL2 Rearrangement (18q21)
BCL6 Rearrangement (3q27)
IGH Rearrangement (14q32)
PCR (If needed for MRD or to confirm diagnosis)
B-Cell Lymphoma
T-Cell Lymphoma
IHC (If needed for subclassification)

FLOW CYTOMETRY PANELS

Myeloid, B- & T- Cell Panel Analysis:

CD2, CD3, CD4, CD5, CD7, CD8, CD10, CD11b, CD11c, CD13, CD14, CD15, CD16, CD19, CD20, CD33, CD34, CD38, CD45, CD56, CD64, CD117, Kappa, Lambda, HLA-DR

B- and T-Cell Panel Analysis:

CD2, CD3, CD4, CD5, CD7, CD8, CD10, CD11c, CD13, CD14, CD16, CD19, CD20, CD22, CD23, CD38, CD45, CD56, Kappa, Lambda, FMIC7

Plasma Cell Panel Analysis:

CD19, CD38, CD45, CD56, CD117, CD138, cKappa, cLambda

CLL/SLL ZAP-70 Panel Analysis:

ZAP-70, CD3, CD5, CD19, CD45

PNH Panel Analysis:

CD14, CD15, CD24, CD33, CD45, FLAER
RBC Reflex: add CD59, CD235a

Only the minimum number of markers necessary to arrive at a final diagnosis will be used and are determined by the suspected diagnosis, histology and working diagnosis.

See Clariant FISH Probe Library for complete FISH probe/panel listing.