Roswell Park Comprehensive Cancer Center
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TESTING REQUISITION FORM

Date & Time Sample 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 COG #
	Ordering Physician MRN
	Treating Physician and Phone Number

FLOW CYTOMETRY TEST REQUEST

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

Clinical Diagnosis *IMPORTANT: Please provide clinical information (check boxes below)*

☐ Leukemia ☐ Myelodysplastic Syndrome(MDS) ☐ Known PNH ☐ Other__________
☐ Lymphoma ☐ Myeloma ☐ Newly Diagnosed
☐ Aplastic Anemia (AA) ☐ Unexplained Cytopenia ☐ Post Transplant

Select one of the following:

☐ Leukemia screen	☐ T-Lymphoproliferative	☐ AML MRD	☐ CMV T Cell
☐ MDS/CML	☐ Multiple Myeloma	☐ Precursor B Cell MRD	☐ CD34 Count
☐ Lymphoma / ALL	☐ NKT-LGL	☐ CLL / Mantle Cell MRD	☐ CD4/CD8
☐ Myeloma	☐ PNH (Blood Only)	☐ Myeloma MRD	☐ Other (Specify)

Shipping Instructions

Blood and bone marrow specimens for Flow Cytometry 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 1 -2 mL (depending on cellularity) 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. Specimens should be shipped at ambient temperature. Samples accompanied by this completed request form should be tubed to station #621 or shipped to the address above via FedEx using standard next day service. If shipped by FedEX on a Friday clearly mark the FedEX shipping form for Saturday delivery. For tissue samples, mince into small 1-5 mm pieces, and place into a small capped tube with RPMI or comparable tissue culture media. For 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 ____________________ City ____________________ Zip ____________ ☐ FAX: ______________ ☐ EMAIL: ______________	Lab ID # Comments