

SHADED AREAS FOR PATIENT INFORMATION REQUIRED

PATIENT LAST NAME		FIRST NAME		MI	COLLECTION DATE	TIME	REPORT	STAT
					mm dd yy	AM/ PM	<input type="checkbox"/> CALL <input type="checkbox"/> FAX	<input type="checkbox"/>
DOB		GENDER		PT. ID# / ADDITIONAL INFO				
mm dd yyyy		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE						
SSN		BILL						
		<input type="checkbox"/> OFFICE/CLIENT <input type="checkbox"/> PATIENT INSURANCE						
PATIENT INSURANCE ATTACH COPY OF FRONT AND BACK OF INSURANCE CARD AND ATTACH COPY OF FRONT OF DRIVERS LICENSE IF UNABLE TO OBTAIN COPY OF REQUIRED INFORMATION ALL FIELDS BELOW ARE REQUIRED GUARANTOR NAME/DOB (REQUIRED IF PATIENT IS A MINOR) ADDRESS CITY STATE ZIP PRIMARY INSURANCE <input type="checkbox"/> MEDICARE IN-PATIENT <input type="checkbox"/> MEDICARE OUT-PATIENT <input type="checkbox"/> MEDICAID <input type="checkbox"/> INSURANCE POLICY ID# GROUP ID# INSURANCE COMPANY PHONE NUMBER INSURANCE COMPANY ADDRESS CITY STATE ZIP EFFECTIVE DATE / / ICD-10 #1 ICD-10 #2 ICD-10 #3								
PHYSICIAN: Phone: Fax: PATHOLOGIST: Phone: Fax: Account Number Account Name Address City State Zip Phone: Fax:								
<input type="checkbox"/> ABN ATTACHED <input type="checkbox"/> PRIOR AUTHORIZATION ATTACHED NOTICE: WHEN ORDERING TESTS FOR WHICH MEDICARE REIMBURSEMENT WILL BE SOUGHT, PHYSICIANS SHOULD ONLY ORDER TESTS THAT ARE MEDICALLY NECESSARY FOR THE DIAGNOSIS OR TREATMENT OF A PATIENT RATHER THAN FOR SCREENING PURPOSES. FOR MORE INFORMATION SEE: reglab.org/billingcompliance/								

Please provide complete information for each of the following sections and include a recent CBC and differential where indicated.

NOTICE: Additional reference laboratory testing may be required at the discretion of the pathologist to establish or confirm a diagnosis. If additional testing is needed the client or patient may receive an invoice for additional testing from the reference laboratory. ☐ Check the box if additional reference laboratory testing is not desired. Please note that a definitive diagnosis may not be possible.

<p>ANALYSIS REQUESTED</p> <p><input type="checkbox"/> Slide Consultation <input type="checkbox"/> Bone Marrow Evaluation <input type="checkbox"/> Lymph Node/Tissue Evaluation <input type="checkbox"/> Conventional Cytogenetics <input type="checkbox"/> FISH Cytogenetics Specify: _____</p> <p>Molecular Studies</p> <p><input type="checkbox"/> BCR/ABL1 Translocation, Qualitative (p210 & p190, for diagnosis) <input type="checkbox"/> BCR/ABL1 Translocation, Quantitative (p210 only, for therapy monitoring) <input type="checkbox"/> BRAF Mutation (p.V600E) <input type="checkbox"/> FLT3 Mutation (Internal Tandem Duplication) <input type="checkbox"/> NPM1 Mutation <input type="checkbox"/> IDH1 and IDH2 Mutation <input type="checkbox"/> PML/RARA translocation by RT-PCR (non-quantitative, for Minimal Residual Disease) <input type="checkbox"/> IgH Heavy Chain Gene Rearrangement <input type="checkbox"/> JAK2 (p.V617F) Mutation <input type="checkbox"/> CALR mutation <input type="checkbox"/> MPL mutation <input type="checkbox"/> KIT p.D816 mutation (for Systemic Mastocytosis) <input type="checkbox"/> T-Cell Receptor Gamma Chain Gene Rearrangement <input type="checkbox"/> Other: _____</p> <p>Flow Cytometry Studies</p> <p><input type="checkbox"/> Flow Cytometry Initial Diagnostic Evaluation* <input type="checkbox"/> Flow Cytometry Remission Assessment* *Include recent CBC and differential</p> <p>SPECIMEN TYPE</p> <p><input type="checkbox"/> Whole Blood <input type="checkbox"/> Bone Marrow Aspirate <input type="checkbox"/> Bone Marrow Core <input type="checkbox"/> Bone Marrow Particles/Clot <input type="checkbox"/> Fluid (Indicate Source) _____ <input type="checkbox"/> Tissue (Indicate Source) _____ <input type="checkbox"/> Blocks/Slides (Indicate Source) _____ <input type="checkbox"/> Other (Indicate Source) _____</p>	<p>PATIENT HISTORY AND PERTINENT LAB DATA</p> <p>Specify:</p> <p>DIAGNOSTIC HISTORY/SUSPECTED DIAGNOSIS</p> <p>Lymphoma</p> <p><input type="checkbox"/> Non-Hodgkin Lymphoma <input type="checkbox"/> Hodgkin Lymphoma <input type="checkbox"/> Multiple Myeloma <input type="checkbox"/> Unknown Type</p> <p>Leukemia:</p> <p><input type="checkbox"/> Acute Lymphoblastic Leukemia <input type="checkbox"/> Chronic Lymphocytic Leukemia <input type="checkbox"/> Acute Myelogenous Leukemia <input type="checkbox"/> Chronic Myelogenous Leukemia <input type="checkbox"/> Hairy Cell Leukemia <input type="checkbox"/> Myelodysplastic Syndrome <input type="checkbox"/> Myeloproliferative Disorder <input type="checkbox"/> Unknown Type</p> <p>Other Diagnosis:</p> <p><input type="checkbox"/> Metastatic Tumor <input type="checkbox"/> Aplastic Anemia <input type="checkbox"/> Immunodeficiency <input type="checkbox"/> Other: _____</p> <p>RECENT TREATMENT HISTORY</p> <p><input type="checkbox"/> Chemotherapy <input type="checkbox"/> Irradiation <input type="checkbox"/> Antibody <input type="checkbox"/> Growth Factor <input type="checkbox"/> Autologous BMT/PSCT <input type="checkbox"/> Allogeneic BMT/PSCT <input type="checkbox"/> Other: _____</p> <p>Date of BMT/PSCT: _____</p> <p>Type and Date of Last Treatment: _____</p>
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Hematopathology Requests

Note: Specimens are time and temperature sensitive. Include a recent CBC and differential with the test request. RPMI preservative available from Regional Pathology Services.

If test needs to be performed on the weekends, call to schedule with Regional Pathology Services, 402-559-6420 or 1-800-334-0459

RPS after hours pager: 402-888-2086

Flow Cytometry Information

Hours: Monday-Saturday: 0730-1700. Sunday: On-call 0730-1700 (Pager: 888-5905)

Bone Marrow Lab Information

Hours: Monday-Friday 0730-1700 (Pager 402-888-0109)

Testing Supplies

Regional Pathology Services furnishes specimen-collection supplies for use by clients that send tests to us.

Supplies are ordered online at reglab.org/customer-service/supply-orders/testing-supplies and log-on information may be obtained by calling client services

Toll Free: 800-334-0459

Phone: 402-559-6420

Courier Services

Regional Pathology Services offers an extensive courier network, which includes contracted land and air courier services. Contracted land specimen pickup is provided at no charge for specimens tested by Regional Pathology Services or our designated reference laboratories.

To inquire about scheduled stops and after hours courier service, call client services Toll Free 800-334-0459
Phone 402-559-6420

If shipping specimens address to:
Regional Pathology Services
University of Nebraska Medical Center
668 S 41st St., MSB 3500
Omaha, NE 68105-1180

Transport Instructions:

Specimen Handling/Shipping

To ensure the safety of personnel and the community, proper handling of specimens for shipment is mandatory. Specimens will be rejected if submitted improperly. The shipper is responsible for the proper packaging and shipping of all specimens. Shippers must be trained and certified by their employer to be able to prepare and ship packages containing diagnostic specimens, biological substances and infectious substances. Rules of the various agencies involved may differ, and may change regularly. Specimen must have at least two patient identifiers and be packaged in sealed plastic bags to prevent leakage or contamination. Place accompanying paperwork in the bag pocket, away from the specimen. Practice universal blood and body fluid precautions when handling specimens.

For tests that require scheduling or special arrangements prior to specimen collection, refer to the Online Test Menu at reglab.org for more information.

Questions?

Contact client services at 800-334-0459