B-ALL Minimal Residual Disease Flow Cytometry Requisition (Bone Marrow, Peripheral Blood)

Pathology and Laboratory Medicine
501 Sixth Avenue South
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Phone: 727-767-4261 Fax: 727-767-8514

Patient Name: _____ MR#: _____

DOB: _____ ICD-10: _____ Gender: ☐ Male ☐ Female

Ordering Provider: _____ Provider Phone #: _____

Signature (and Credentials): _____ Date Ordered: _____

Provider address: _____

_____

Copy Results to: _____ Fax Results to: _____

TEST ORDERED

Flow Cytometry, COG B-ALL MRD Panel

☐ Evaluate for CD22 expression if abnormal population is detected (additional charge).

Please attach a copy of the pre-treatment flow cytometry report for post-treatment samples.

CLINICAL INFORMATION (REQUIRED)

COG Patient:	☐ Yes	☐ No	
Clinical Status:	☐ Remission	☐ Relapse	☐ Unknown
Day 8 Evaluation:	☐ Yes	☐ No	
Day 29 Evaluation:	☐ Yes	☐ No	
History of Anti-CD19 CAR-T Therapy:	☐ Yes*	☐ No	

***If Yes, specimen will be forwarded to Johns Hopkins Baltimore for analysis.**

SPECIMEN SOURCE

Date of Collection: _____ Time of Collection: _____

☐ **Bone Marrow Aspirate** Collect >2 ML liquid bone marrow into Heparin (green top, preferred) tube or EDTA (lavender top, acceptable).

Site: ☐ Left Iliac Crest ☐ Right Iliac Crest ☐ Other, specify: _____

☐ **Peripheral Blood** Collect >2 ML liquid bone marrow into Heparin (green top, preferred) tube or EDTA (lavender top, acceptable).

Note: Lithium Heparin or ACD (pale yellow gel separator) is **NOT** acceptable.

Place patient label here