HRPLABS
HATO REY PATHOLOGY ASSOCIATES, INC

Client No.

Space Reserved for Laboratory Use

Specimen No. _____

HEMATOPATHOLOGY SERVICE REQUEST

Patient Information □**Non-Hospital** (Outreach /Clinic patient) □ **Hospital** (In/Out patient at time of procedure)

Patient's Name: _____ **Record No.**_____

Gender: _____ **DOB:** Month / Day / Year **Age:** _____ **Phone:** _____

Mobile: _____ **Postal Address:** _____

e-mail: _____

Medical Insurance: _____ □**Check if patient wants to receive bill for any deductibles via email.**

Contract #_____**Group #** _____

2nd Insurance: _____ **Contract:** _____ **Group:** _____

***Pathologists may order additional testing based on medical necessity.**

Notification to the Patient: All samples sent to HRP LABS will be processed and diagnosed, and its outcome will be sent directly to the physician. If any deductible or copay applies or if you don't have medical insurance, you will receive an invoice for the payment. Toda muestra enviada a HRP LABS será procesada y diagnosticada y el resultado será enviado a su médico. En caso de que haya algún deducible o copago, o de usted no estar cubierto por un seguro médico, recibirá factura y será responsable del pago de la misma.

Patient's Signature: _____

CLINICAL HISTORY

Clinical History:

_____

□ B Symptoms □ M-Spike

□ Organomegaly □ Immunodeficiency

□ Weight Loss

□ Lymphadenopathy _____ cm

Omit if CBC Report is Submited.

□ Initial Evaluation
□ Staging
□ Relapse
□ BMT Evaluation
□ Post-therapry / Re-staging

Therapy: _____

□ Current □ Prior

CLINICAL IMPRESSION / DIAGNOSIS

ICD-10	ICD-10	ICD-10	ICD-10	ICD-10

□ MPN _____ □ Lymphoma _____ □ Hodgkin □ NHL

□ MDS _____ □ Acute Leukemia _____ □ CLL/SLL

□ Plasma Cell Neoplasm _____ □ Other: _____

SPECIMEN SUBMITTED

Collection Date: Mo /Day /Year **Time:** **Site:** □ **Rt. Iliac Crest** □ **Lt. Iliac Crest** □ **Other:** _____

□ BM Bx □ BM Clot

□ BM Aspirate #_____ Na-Heparin (green) #_____ EDTA (purple) #_____ Smears

□ Peripheral Blood #_____ Na-Heparin (green) #_____ EDTA (purple) #_____ Smears

TEST REQUESTED

☐ Morphology ☐ Flow Cytometry ☐ Cytogenetics ☐ FISH: _____ ☐ Other Molecular:

☐ TCR ☐ JAK2 (V617F) ☐ Reflex JAK2 Exon 12 _____

☐ BCR-ABL (Initial DX) ☐ BCR-ABL (Quantitative) if follow-up please attach previous report. _____

Physician's name: _____ **Lic.** _____

NPI #_____ **Physician's Signature:** _____

When ordering tests, providers should only order tests that are medically necessary for the diagnosis or treatment of a patient, generally not for screening. Only a few screening tests are covered by most government and third party payors for certain conditions at specific intervals. When ordering tests that are subject to ABN guidelines, refer to the policies published by your Medicare Administrative Contractor (MAC), or CMS. If testing does not come under Medicare guidelines for payment a signed beneficiary notice must be included in advance.

Red fields and patient information must be completed to avoid delay in processing or sample rejection.