



NAME: _____

HSN: _____

D.O.B.: _____

DEPARTMENT OF LABORATORY MEDICINE
FLOW CYTOMETRY REQUISITION

RUH SCH SPH Other _____

Requesting physician: _____

Copies of report to 1. _____

2. _____

Collection date and time: _____

CLINICAL INFORMATION (past and present):

SPECIMEN TYPE AND SITE (source):

- Peripheral Blood CSF
- Bone marrow (specify site): _____
- Lymph node (specify site): _____
- Biopsy (specify site): _____
- Fluid (specify site): _____
- Other (specify type and site): _____

TEST REQUESTED:

- CD4C8 (CD3/CD4/CD8, T Cell Subsets in Peripheral Blood [Percent and Absolute Values])
- CD34P Absolute CD34 (HPC); pre-harvest only
- FLOWC All other testing by Flow Cytometry (specify)
 - Lymphoma, Chronic Lymphocytic Leukemia
 - Acute Leukemia
 - Myeloma or other plasma cell dyscrasia
 - CD19, CD20
 - Other (specify) _____

NOTE: Adequate clinical information is essential for accurate diagnosis.

NOT FILED ON PERMANENT HEALTH RECORD