

PHONE: (314) 977-7864 • FAX: (314) 977-3221 • 1402 S. GRAND BLVD., ST. LOUIS, MO 63104

PATIENT NAME (LAST, FIRST, MI):		DATE OF BIRTH:	SEX: <input type="checkbox"/> M <input type="checkbox"/> F	DIAGNOSIS CODE:
DATE OF COLLECTION:	TIME OF COLLECTION: <input type="checkbox"/> AM <input type="checkbox"/> PM	ACCESSION #:		
PLACE OF SERVICE SPECIMEN WAS OBTAINED: INPATIENT ENTER ADMIT DATE: ___/___/___				H #:
				<input type="checkbox"/> OUTPATIENT <input type="checkbox"/> ASC <input type="checkbox"/> OFFICE
REFERRING INSTITUTION:		SPECIMEN TYPE:		
ADDRESS:		CITY:	STATE:	ZIP CODE:
PHONE:	FAX:	REFERRING PHYSICIAN SIGNATURE:		DATE:

AVAILABLE TESTING

- Flow Cytometry Immunophenotyping
(Leukemia/Lymphoma)
- Hematopathology Consult
- CD34+ Stem Cell Enumeration
- T cell Lymph Subset Panel
(CD3, CD4, CD8, Ratio)
- Immune Deficiency Panel
- Acquired Immune Deficiency Panel
- Rituximab Therapy Evaluation Panel

ACCEPTABLE SPECIMENS

- Bone Marrow
(Sodium Heparin – green tops)
(EDTA – purple tops)
- Peripheral Blood
(Sodium Heparin – green tops)
(EDTA – purple tops)
- Body Fluids
(Sterile container or Sodium Heparin Tubes)
- Fresh Tissue
(Kept Cold – NOT FROZEN)
(Kept Moist with Saline Gauze or in RPMI Fluid)

SPECIAL INSTRUCTIONS / NOTES: