UT Health San Antonio
Pathology & Laboratory Medicine

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Web Page: http://pathology.uthscsa.edu/strl/cytometry/

FLOW CYTOMETRY LABORATORY

Request for Flow Cytometry Studies

Patient's Name: ______________________ Birth Date/Age:________ Sex:___ Ethnicity:________
First (Middle Initial) Last

Ordering Facility: ☐ VA ☐ UH ☐ Other________ Address:______________________
Street City State Zip

Hospital/Pt ID #________________ Diagnosis:______________________

Specimen Submitted:______________________ ☐ BM ☐ PB ☐ LN ☐ Other______________

Specimen #____________________ Specimen Collection Date:______________ Collection Time:____________
AM PM

Requesting Physician (required)______________________ Telephone:____________ FAX:____________

Physician Address:______________________
Street City State Zip

Additional reports to:______________________
Street Fax Phone

____
Street City State Zip

Pertinent Clinical History and Laboratory Date:

Tests Requested (**please see http://pathology.uthscsa.edu/strl/cytometry/ for Specimen & Sending Requirements)**

- ☐ Immunophenotyping for Leukemias
- ☐ Immunophenotyping for Lymphomas
- ☐ Immunophenotyping for Plasma Cell Neoplasms
- ☐ Hemoglobin F Analysis (HgbF)
- ☐ Paroxysmal Nocturnal Hemoglobinuria Testing (PNH)
- ☐ Other ____________________

Note: Specimens will NOT be processed without billing information

☐ **Bill Patient:**______________________
Street City State Zip Phone

☐ **Bill Facility:**______________________
Facility Name Street City State Zip Patient ID#

☐ **Bill Insurance:**______________________
Insurance Company Name and Address

____
Name of Insured Policy # Group#

____
Patient Address Telephone # Date of Birth

☐ **Bill Research Account:**______________________
Principal Investigator Account #

Do not write in this space
FLOW#