



YOSEMITE PATHOLOGY™
Quality diagnostics for optimum patient care

HEMAQ™ Hematopathology

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www.ypmg.com



NOTE: CA TITLE 17 (SEC. 1050) REQUIRES THE PHYSICIAN TO PROVIDE PATIENT'S DOB, SOURCE OF SPECIMEN, LMP, HISTORY, THERAPY, AND SLIDE/VIAL LABELED APPROPRIATELY - TWO (2) IDENTIFIERS.

Date Collected:		Patient Name:		Birth Date:	Sex:
Street Address/Apt #:			City:	State:	Zip:
Responsible Party Phone #:		Social Security No.:	MRN #:	Physician Performing Procedure:	
Type of Billing:	<input type="checkbox"/> Patient	<input type="checkbox"/> Insurance	<input type="checkbox"/> Medicare	Diagnosis Codes:	
	<input type="checkbox"/> Medi-Cal	<input type="checkbox"/> Client	<input type="checkbox"/> Slide Prep Only		
(Please attach a copy of the front and back of the patients insurance card.)				Copy To Physician(s):	

Physician Signature: _____

CLINICAL HISTORY

Signs and/or Symptoms: _____

SPECIMEN(S) SUBMITTED

Bone Marrow Biopsy: Core: _____ Clot: _____ Touch Prep: _____ YHQ1234567

Bone Marrow Aspirate: Green Top(s) (Sodium Heparin): _____ Purple Top(s) (EDTA): _____ Smear: _____

Peripheral Blood: Green Top(s) (Sodium Heparin): _____ Purple Top(s) (EDTA): _____ Smear: _____

Tissue Biopsy: Tissue Type: _____ Location: _____

Fixative: 10% Formalin RPMI Saline Other: _____

Paraffin Block(s) or Slide(s): _____ Specimen ID: _____

Other (FNA, Body Fluid, etc.): _____ Location: _____

COMPREHENSIVE DIAGNOSTIC ANALYSIS

Comprehensive Diagnostic Analysis:

A comprehensive analysis which includes a review of clinical history, global histomorphologic review, flow cytometry, cytogenetics, FISH, molecular testing, and a summary with correlation of all technologies. Please attach any previous reports which have not been issued by PPMG and CBC report. All tests will be ordered under the discretion of a Hematopathologist.

INDIVIDUAL DIAGNOSTIC/PROGNOSTIC TEST

<p>Histomorphology:</p> <p><input type="checkbox"/> Global Histomorphology <input type="checkbox"/> Consult</p> <p><input type="checkbox"/> Tech Only- H&E, Iron, & Reticulin Stains</p> <p>Flow Cytometry:</p> <p><input type="checkbox"/> Leukemia/Lymphoma <input type="checkbox"/> ZAP-70 (Peripheral blood only)</p> <p><input type="checkbox"/> PNH (Peripheral blood only) <input type="checkbox"/> Plasma Cell</p> <p>Cytogenetics:</p> <p><input type="checkbox"/> Cytogenetic Analysis Only <input type="checkbox"/> With reflex to FISH <input type="checkbox"/> MPD</p> <p>FISH (Panels):</p> <p><input type="checkbox"/> AML <input type="checkbox"/> ALL <input type="checkbox"/> CLL <input type="checkbox"/> CML <input type="checkbox"/> Eosinophilia <input type="checkbox"/> MDS</p> <p><input type="checkbox"/> MM <input type="checkbox"/> NHL <input type="checkbox"/> Individual Probes: _____</p> <p>Array Comparative Genomic Hybridization:</p> <p><input type="checkbox"/> AML <input type="checkbox"/> CLL <input type="checkbox"/> MDS <input type="checkbox"/> Myeloma</p>	<p>Molecular:</p> <p><input type="checkbox"/> BCR/ABL by RT-PCR <input type="checkbox"/> PML/RARA by RT-PCR</p> <p><input type="checkbox"/> JAK2 V617F by PCR <input type="checkbox"/> IgVH Mutation Analysis</p> <p><input type="checkbox"/> MPL by PCR <input type="checkbox"/> B-Cell Clonality by PCR</p> <p><input type="checkbox"/> JAK2 Exon 12 by PCR <input type="checkbox"/> T-Cell Clonality by PCR</p> <p><input type="checkbox"/> AML Prognostic Panel by PCR (FLT-3, NPM1, c-KIT, CEBPA) <input type="checkbox"/> BCL-1 by PCR</p> <p><input type="checkbox"/> BCL-2 by PCR</p> <p><input type="checkbox"/> Other: _____</p>
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Please Attach A Copy Of The Following: CBC, History (Past Reports if Possible), and Face Sheet/Insurance

Pt. Name: _____	Pt. Name: _____	Pt. Name: _____	Pt. Name: _____
Source: _____	Source: _____	Source: _____	Source: _____
YHQ1234567	YHQ1234567	YHQ1234567	YHQ1234567