Washington University in St. Louis
School of Medicine

FLOW CYTOMETRY IMMUNO PHENOTYPING

314-362-4628
St. Louis, Missouri 63110

Barnes-Jewish Hospital
BJC HealthCare

COLLECTION INFORMATION: ☐ AM ☐ PM
DATE _____ TIME _____ INITIALS _____

ACCOUNT INFORMATION

NAME
ADDRESS
CITY STATE ZIP
PHONE

ORDERING PHYSICIAN

BILL TO:
☐ ACCOUNT ☐ PATIENT/INSURANCE ☐ ALTERNATE

SEND ADDITIONAL COPY OF REPORT TO:
CLIENT NUMBER/PHYSICIAN NAME PHONE/FAX NUM.
PHYSICIAN'S ADDRESS CITY, STATE, ZIP

BJH REGISTRATION #

REGISTERED BY

PATIENT

PATIENT'S NAME (LAST) (FIRST) (MI) SEX DATE OF BIRTH MO DAY YR PATIENT'S SS #
PATIENT'S ADDRESS CITY STATE ZIP PHONE
REFERENCE # DIAGNOSIS REQUIRED

RESP. PARTY

PATIENT'S RELATIONSHIP TO RESPONSIBLE PARTY ☐ 1-SELF ☐ 2-SPOUSE ☐ 3-CHILD ☐ 4-OTHER
NAME OF RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT) SOCIAL SECURITY (INSURED SS#):
ADDRESS OF RESPONSIBLE PARTY APT # DATE OF BIRTH MO DAY YR
CITY STATE ZIP
MEDICAID # STATE MEDICARE # (INCLUDE PREFIX/SUFFIX) ☐ PRIMARY ☐ SECONDARY MEDICARE RETIREMENT OR DISABILITY DATE:

INSURANCE

INSURANCE COMPANY NAME PLAN CARRIER CODE
SUBSCRIBER / MEMBER # LOCATION GROUP #
INSURANCE ADDRESS PHYSICIAN'S PROVIDER #
CITY STATE ZIP
EMPLOYER'S NAME OR NUMBER WORKER'S COMP ☐ YES ☐ NO

CLINICAL HISTORY AND DIAGNOSIS:

SPECIMEN TYPE:

	Tube Type
☐ Peripheral Blood - Immune testing:	LAV
☐ Peripheral Blood Leuk/Lym workup:	LAV / 2 DK GRN
☐ Peripheral Blood PNH:	LAV / DK GRN
☐ Bone Marrow: _____	LAV / DK GRN / Core-Formalin
☐ Fluid: _____	FL
☐ Tissue: _____	
☐ FNA (Fine Needle Aspiration): _____	
☐ Other:	

SAMPLE SUBMITTED:
COLLECTION TIME : AM PM COLLECTION DATE MO DAY YEAR

LABORATORY TEST

- ☐ Lymphoma WorkUp (Lymphoproliferative disorder ex: CLL, NHL, HCL)
- ☐ Leukemia WorkUp (Acute Leukemia ex AML, ALL, ANLL)
- ☐ PNH Profile Includes RBC-CD59, WBC-CD59 and FLAER
- ☐ Sezary Cell WorkUp
- ☐ Other (Please Specify) _____
- ☐ Other Flow Test: Fetal Red Blood Cell Percentage
- ☐ Lymphocyte Subpopulation 7 (CD3, CD4, CD8, CD19, CD16+56, CD2, HLA-DR)
- ☐ Lymphocyte Subpopulation 13 (CD3, CD4, CD8, CD19, CD16+56, CD16, CD2, CD40, HLA-DR, TCR)
- ☐ Immune Competence (CD3, CD4, CD8, CD19, CD16+56, CD4/CD8 Ratio)
- ☐ Immune Deficiency (CD4, CD8, CD4/CD8 Ratio)
- ☐ CD4
- ☐ CD45RA/CD45RO
- ☐ Adhesion Panel (CD11a, CD11b, CD11c, CD15, CD18)

CONTAINERS RECEIVED →	GRN DK GRN	FL FLUID	OT OTHER	COLLECTION TIME : AM PM	INITIALS

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