

## REQUIRED ITEMS

1. CBC    2. Clinical Information    3. ICD 10 Codes    4. Face Sheet (Front and Back Copy of the Patient's Insurance Card and Demographic Information)    5. Provider's Signature

## PATIENT INFORMATION

Last Name \_\_\_\_\_  
 First Name \_\_\_\_\_ M.I. \_\_\_\_\_  
 DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  Male  Female  Other \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Patient ID \_\_\_\_\_

## PROVIDER INFORMATION

Authorized Provider Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Please Fax Duplicate Report to Additional Provider \_\_\_\_\_ Fax \_\_\_\_\_

## BILLING INFORMATION

Bill to:  Insurance  Medicare  Referring Facility (Hospital/Client)  Split Billing - Client (TC) and Insurance (PC)  Patient  
 Patient Status:  Inpatient (Hospital)  Outpatient (Hospital)  Non-Hospital  ASC Prior Authorization # \_\_\_\_\_

## CLINICAL INFORMATION

Indication(s) for Testing: \_\_\_\_\_  
 ICD-10 Codes: \_\_\_\_\_ Disease:  New Diagnosis  Refractory  Recurrent/Relapsed  Follow-Up

## SPECIMEN INFORMATION

Date Collected \_\_\_\_/\_\_\_\_/\_\_\_\_ Time Collected \_\_\_\_:\_\_\_\_  AM  PM  
 Date Retrieved \_\_\_\_/\_\_\_\_/\_\_\_\_ Date Discharged \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Specimen ID \_\_\_\_\_

**PERIPHERAL BLOOD**  
 Smears # \_\_\_\_\_ Purple Tops # \_\_\_\_\_ Green Tops # \_\_\_\_\_  
**BONE MARROW** (  LEFT /  RIGHT )  
 Aspirate  Clot  Core  
 Touch Preps # \_\_\_\_\_ Purple Tops # \_\_\_\_\_  
 Smears # \_\_\_\_\_ Green Tops # \_\_\_\_\_

**BODY FLUID** \_\_\_\_\_  
**LYMPH NODE** \_\_\_\_\_  
**FINE NEEDLE ASPIRATE** \_\_\_\_\_  
**PARAFFIN BLOCKS #** \_\_\_\_\_  
**SLIDES** \_\_\_\_\_  
**OTHER** \_\_\_\_\_

## TEST REQUESTED (FOR MORE TESTING INFORMATION, VISIT COREPATH.US)

**20/20 CORE EVALUATION REPORT**  
 Pathology Consultation with Morphologic Interpretation and/or Ancillary Studies (Flow Cytometry, Routine Chromosome Analysis, FISH, PCR and/or NGS); if clinically indicated.

MORPHOLOGY     CONSULT  
**FLOW CYTOMETRY** Please select service:  Global  TC  PC  
 Acute Leukemia Panel  Myeloma Panel  Immunodeficiency Panel  
 Lymphoma Panel  MRD for CLL  HIV  
 CLL Prognostic Panel  MRD for Multiple Myeloma  COVID-19  
 PNH Panel  Sezary Syndrome Panel  Allergy/Autoimmune  
 Other: \_\_\_\_\_  Immune Dysregulation

**CYTOGENETICS**  Routine Chromosome Analysis

**FISH PANELS** Please select service:  Global  TC  
 ALL  CML  Eosinophilia  
 AML  Myeloma  High-Grade/Large B-cell Lymphoma  
 CLL  MDS  Small B-cell NHL Panel  
 Other: \_\_\_\_\_

**FISH PROBES**

<input type="checkbox"/> ALK/Lymphoma (2p23)	<input type="checkbox"/> IGH/CCND1 t(11;14)	<input type="checkbox"/> RUNX1T1/RUNX1 (ETO/AML1) t(8;21)
<input type="checkbox"/> ATM (11q22)	<input type="checkbox"/> IGH/FGFR3 t(4;14)	<input type="checkbox"/> TP53 (17p13)
<input type="checkbox"/> BCL6 (3q27)	<input type="checkbox"/> IGH/MAF t(14;16)	<input type="checkbox"/> 5q-/-5
<input type="checkbox"/> BCR-ABL1/ASS1 t(9;22)	<input type="checkbox"/> IGH/MYC t(8;14)	<input type="checkbox"/> 6q21/6q23
<input type="checkbox"/> CBFMB/MYH11 inv(16)	<input type="checkbox"/> MALT1 (18q21)	<input type="checkbox"/> 7q-/-7
<input type="checkbox"/> CKS1B/CDKN2C (1p/1q)	<input type="checkbox"/> KMT2A (MLL; 11q23)	<input type="checkbox"/> +8
<input type="checkbox"/> ETV6/RUNX1 t(12;21)	<input type="checkbox"/> MYC (8q24)	<input type="checkbox"/> +12
<input type="checkbox"/> FGFR1 (8p11)	<input type="checkbox"/> PDGFRA (4q12)	<input type="checkbox"/> 13q-/-13
<input type="checkbox"/> IGH (14q32)	<input type="checkbox"/> PDGFRB (5q32)	<input type="checkbox"/> 20q-
<input type="checkbox"/> IGH/BCL2 t(14;18)	<input type="checkbox"/> PML/RARA t(15;17)	

POC Ploidy: FISH on Formalin Fixed Products of Conception, Common Trisomies and Triploidies, Chromosomes 13/16/18/21/X/Y  
 Other: \_\_\_\_\_

**MOLECULAR PROFILES**

CORE MPN Limited Profile (JAK2 V617F, JAK2 Exon 12-15, CALR, MPL)\*\*  
 CORE Myeloid Extended Profile (MDS/MPN)\*\*  
 CORE Acute Leukemia Expression-Fusion Profile (AML/ALL)★  
 CORE Lymphoma/Myeloma Expression-Fusion Profile★  
 CORE Liquid Biopsy (EDTA Blood; Cell Free DNA)\*\*

\*\* DNA    ★ DNA and RNA

**MOLECULAR ASSAYS**

<input type="checkbox"/> JAK2 V617F	<input type="checkbox"/> T-Cell Clonality	<input type="checkbox"/> EZH2 Mutation
<input type="checkbox"/> JAK2 Exon 12-15	<input type="checkbox"/> IgVH Hypermutation	<input type="checkbox"/> KIT D816V Mutation
<input type="checkbox"/> CALR Mutation	<input type="checkbox"/> BRAF V600E Mutation	<input type="checkbox"/> MLL-PTD Mutation
<input type="checkbox"/> MPL Mutation	<input type="checkbox"/> TP53 Mutation	<input type="checkbox"/> SRSF2 Mutation
<input type="checkbox"/> BCR-ABL1 p210/p190 (PCR - Quantitative)	<input type="checkbox"/> STAT3 Mutation	<input type="checkbox"/> TET2 Mutation
<input type="checkbox"/> MYD88 L265P Mutation	<input type="checkbox"/> CEBPA Mutation	<input type="checkbox"/> U2AF1 Mutation
<input type="checkbox"/> FLT3 Mutation	<input type="checkbox"/> ABL1 Kinase Domain Mutation	<input type="checkbox"/> ZRSR2 Mutation
<input type="checkbox"/> FLT3/NPM1 Mutation	<input type="checkbox"/> ASXL1 Mutation	
<input type="checkbox"/> NPM1 Mutation	<input type="checkbox"/> BTK Inhibitor Acquired Resistance Panel (BTK and PLC-gamma2)	
<input type="checkbox"/> PML/RARA (PCR)	<input type="checkbox"/> BTK Mutation (C481S Mutation and Others)	
<input type="checkbox"/> IDH1 and 2 Mutation	<input type="checkbox"/> CXCR4 Mutation	
<input type="checkbox"/> SF3B1 Mutation		
<input type="checkbox"/> B-cell Clonality		

**OTHER** \_\_\_\_\_

**LABORATORY USE ONLY**  
 Bone Marrow Clinic Patient

**PREFERRED SPECIMEN REQUIREMENTS**

Specimen Type	Flow Cytometry	Cytogenetics	FISH <sup>1</sup>	Molecular <sup>1</sup>	Immunostains
Peripheral Blood <sup>2</sup>	Lavender <sup>3</sup> or Green Top <sup>4</sup>			Lavender Top <sup>3</sup>	Not Applicable
Bone Marrow					10% Formalin or Paraffin Block
Lymph Node or Tissue (Fresh)	Tissue Media			Tissue Media RNA Fixative or 10% Neutral Buffer	
Formalin Fixed Paraffin Embedded	Not Applicable		Paraffin Block or Unstained Slides	Paraffin Block <sup>5</sup>	Paraffin Block or Unstained Slides
Fine Needle Aspirate	Tissue Media				Cell Block
Body Fluid <sup>6</sup>	Sterile Container				

<sup>1</sup> Decalcified samples not suitable | <sup>2</sup> Please provide copy of CBC if available | <sup>3</sup> Lavender Top: EDTA | <sup>4</sup> Green Top: Sodium Heparin | <sup>5</sup> Only for some tests; contact us for details | <sup>6</sup> Minimum of 5 mL is preferred

**SPECIMEN HANDLING AND TRANSPORTATION**

**Storage:** All specimens should be stored at room temperature.

**Transportation:** Please use cold packs for transportation without placing packs in direct contact with specimens. Please fill out the requisition form completely and place all specimens in a CorePath shipping kit using the pre-printed air bills supplied by CorePath.

**Schedule a Pick-Up:** Call CorePath Laboratories at 1.877.617.4445 to schedule a pick-up. In the San Antonio area, call 210.617.4445 to schedule a courier pick-up.

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**FOR MORE INFORMATION ON TESTING,  
VISIT WWW.COREPATH.US**