

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 6. Name of Person Who Completed Requisition Form

PATIENT INFORMATION

Last Name _____
First Name _____ M.I. _____
DOB MM / DD / YYYY Gender: Male Female Other _____
Address _____
City _____ State _____ Zip _____
Phone _____ Patient ID _____

PROVIDER INFORMATION

The undersigned certifies by completion of this section, that he/she is authorized to order the test(s) listed below and that such test(s) are medically necessary for the care and/or treatment of this patient.
Authorized Provider Signature _____ Date MM DD YYYY
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 MM / DD / YYYY Time Collected : AM PM
Date Retrieved MM / DD / YYYY Date Discharged MM / DD / YYYY
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 Request that CorePath's Board Certified Pathologists review the patient's clinical history and all materials submitted with this order to select the medically necessary tests for a comprehensive analysis and efficient patient care with the end goal of timely guidance for diagnosis, prognosis, risk stratification, staging and treatment by the treating provider. This includes Pathology Consultation with Morphologic interpretation and/or ancillary studies Flow Cytometry, Routine Chromosome Analysis, FISH, PCR and or NGS (from assays/panels outlined here), if clinically indicated.

CONSULT MORPHOLOGY CYTOGENETICS
 Reflex to FISH as medically necessary

FLOW CYTOMETRY Please select service: Global TC PC
 Acute Leukemia Panel High Sensitivity PNH Panel MRD for Multiple Myeloma
 Lymphoma Panel Myeloma Panel Sezary Syndrome Panel
 CLL Prognostic Panel MRD for CLL Other: _____

FISH PANELS Please select service: Global TC
 ALL Multiple Myeloma with Reflex to Eosinophilia
 AML IGH/FGFR3, IGH/CCND1, IGH/ High-Grade/Large B-Cell Lymphoma
 CLL MAF and IGH/MAFB as needed Low-Grade/Small B-Cell Lymphoma
 CML MDS Other: _____

FISH PROBES
 ALK (2p23) Lymphoma Rearrangement IGH/FGFR3 t(4;14)
 ATM (11q22) Deletion IGH/MAF t(14;16)
 BCL6 (3q27) Rearrangement IGH/MAFB t(14;20)
 BCR-ABL1/ASS1 t(9;22) IGH/MYC t(8;14)
 CEBF/ MYH11 inv(16) MALT1 (18q21) Rearrangement
 CEP10/CHIC2/CEP17 KMT2A (MLL; 11q23) Rearrangement
 CKS1B/CDKN2C (1p/1q) MYC (8q24) Rearrangement
 ETV6/RUNX1 (TEL/AML1) t(12;21) PDGFRA (4q12) Deletion/Rearrangement
 FGFR1 (8p11) Rearrangement PDGFRB (5q32) Rearrangement
 IGH (14q32) Rearrangement PML/RARA t(15;17)
 IGH/BCL2 t(14;18) RUNX1T1/RUNX1 (ETO/AML1) t(8;21)
 IGH/CCND1 t(11;14) TCF3 (E2A) (19p13) Rearrangement

OTHER _____

NEXT GENERATION SEQUENCING (NGS) PROFILES

- CORE Myeloid Profile (MDS/MPN)*
 CORE Acute Leukemia Expression-Fusion Profile (AML/ALL)★
 CORE Lymphoma/Myeloma Expression-Fusion Profile★
 CORE Liquid Biopsy (cfDNA and cfRNA)★ 2 EDTA Tubes, Peripheral Blood Only

* DNA ★ DNA and RNA

PCR ASSAYS

- JAK2 V617F Mutation BRAF V600E Mutation
 JAK2 Exon 12-13 CEBPA Mutation
 CALR Mutation CXCR4 Mutation
 MPL Mutation FLT3/NPM1 Mutation
 BCR-ABL1 p210 IDH1 and 2 Mutation
 BCR-ABL1 p190 IgVH Hypermutation
 BCR-ABL1 p210/p190 (PCR - Quantitative) KIT D816V Mutation
 B-Cell Clonality MYD88 L265P Mutation
 T-Cell Clonality PML/RARA (PCR) Fusion Transcript
 ABL1 Kinase Domain Mutation Other: _____

clonoSEQ® ASSAY

For (Disease) _____
Initial Diagnosis _____
Follow-Up _____

Requisition Completed by _____

LABORATORY USE ONLY

Bone Marrow Clinic Patient

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 6. Name of Person Who Completed Requisition Form

PREFERRED SPECIMEN REQUIREMENTS

Specimen Type	Bone Marrow Morphology	Flow Cytometry	Routine Chromosome Analysis ¹	FISH ¹	PCR ¹	NGS	IHC/Immunostains
Peripheral Blood ²	Two (2) smears/slides	2 mL sodium heparin ⁴ or EDTA ³	5 mL sodium heparin ⁴ preferred, EDTA ³ acceptable	5 mL sodium heparin ⁴ preferred, EDTA ³ acceptable	4 mL EDTA ³	5 mL EDTA ³ Liquid Biopsy: 10 mL minimum EDTA ³ or 30-50 ng/μl DNA/RNA in microfuge tube	N/A
Bone Marrow Aspirate	Five (5) smears/slides	2 mL EDTA ³ preferred, sodium heparin ⁴ acceptable	1-2 mL sodium heparin ⁴ preferred, EDTA ³ acceptable	1-2 mL sodium heparin ⁴ preferred, EDTA ³ acceptable	2 mL EDTA ³	2 mL EDTA ³	N/A
Bone Marrow Clot	2 mL clot (volume) in 10% NBF*. Two (2) touch prints.	N/A				One (1) H&E stained slide and six (6) to eight (8) unstained slides.	N/A
Bone Marrow Core Biopsy & Touch Imprints	1 cm core (length) in 10% NBF*. Five (5) touch prints.	1-2 cm core (length) in RPMI	1-2 cm core (length) in RPMI	0.5 cm core (length) in RPMI	1-2 cm core (length) in RPMI	1-2 cm core (length) in RPMI	N/A
Lymph Node/Tissue (Fresh)	N/A	0.5 cm ³ in RPMI. Other fixatives not acceptable.			0.5 cm ³ in RNA fixative or 10% NBF*	0.5 cm ³ tissue in normal saline	FFPE tissue block preferred. 0.5 cm ³ in 10% NBF*.
Formalin Fixed Paraffin Embedded (FFPE) Block or Cut Slides	N/A	N/A	N/A	FFPE tissue block preferred ⁵ . One (1) H&E stained slide and five (5) unstained slides.	FFPE tissue block preferred ⁵ . One (1) H&E stained slide and five (5) unstained slides.	One (1) H&E stained slide and six (6) to eight (8) unstained slides.	Four (4) to five (5) micron thick tissue sections on positively charged slides. Provide at least three (3) slides per requested antibody.
Fine Needle Aspirate (FNA)	N/A	RPMI				RPMI/Cell block	Cell block
Body Fluids	N/A	CSF: 5 mL in sterile container Pleural: 20 mL in ratio of 1 mL sodium heparin or ACD to 100 mL fluid				5 mL fluid/Cell block	Cell block

*NBF = Neutral Buffered Formalin

¹ Decalcified samples not acceptable | ² Please provide copy of CBC if available | ³ EDTA = Lavender Top | ⁴ Sodium Heparin = Green Top | ⁵ Only for some tests; contact us for details or go to www.corepath.us

TEST NOTATIONS

clonoSEQ® is a registered trademark of Adaptive Biotechnologies Corporation.

SPECIMEN HANDLING AND TRANSPORTATION

Storage & Transport: Specimens should be received at CorePath within 72 hours from collection to ensure sample integrity and acceptable cell viability. Ship same day as drawn whenever possible. Peripheral blood and bone marrow should be shipped at room temperature. In hot weather, use cold pack for transport, making sure cold pack is not in direct contact with specimen. Body fluids and tissue should be shipped at 4°C.

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.

© 2026 CorePath Laboratories. All rights reserved.

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