PATHOLOGY CONSULTANTS
specialized diagnostic services

BONE MARROW EXAMINATION FORM

***Request for expedited report as pt's next appt is _____

Please fill out patient info completely and keep a copy for your records

NAME: _____ _____ _____
PLEASE PRINT LAST FIRST MIDDLE

_____ _____/_____/_____ _____ _____ _____
SOCIAL SECURITY # or MR# DOB SEX REFERRING PHYSICIAN COLLECTION DATE & TIME

_____ _____ _____ _____ (_____)_____
STREET ADDRESS CITY STATE ZIP CODE PHONE

BILLING INFORMATION: **Please include a copy of the patient's insurance info.**
☐ Front and back of card are attached ☐ Patient is self-pay ☐ precert attached (if required)

ICD10 CODE:

(Please include a copy of CBC (Hemogram) and a peripheral smear).

CLINICIAN TO FILL OUT:

Reason for biopsy/specific question to address:

_____
_____
_____

☐ **Bone Marrow transplant patient: ☐ NO ☐ YES**
If yes: ☐ allogeneic ☐ autologous ☐ sex mismatch
☐ **Recent or current G-CSF therapy ☐ NO ☐ YES**

SPECIMEN INFORMATION: To be filled in by proceduralist

_____ _____
Collected by **Collection date**

Site: ☐ Right ☐ Left ☐ Bilateral
☐ **SLIDES: Aspirates #_____ (Ideally ___ slides with ___ drops of BM/slide or dry tap)**

If dry tap then prepare an additional 2-4 touch preps & obtain 2nd core in RPMI.

Touch Preps #_____(Ideally 2-4 slides with 3-4 flicked imprints/rolls/per slides)

☐ **BONE MARROW: (# of tubes)____** ☐ **PERIPHERAL BLOOD: (# of tubes)_____**

Core biopsy in B+ fixative (y/n)_____ (ideally 1-2 cm)
2nd core in RPMI (y/n)_____

LAB USE ONLY

A) _____BM Aspirate slides
_____Peripheral Smear
_____Touch Prep(s)
_____Bone marrow bx
_____Bone marrow bx
_____Bone marrow clot
_____Bone marrow clot

☐ Flow sent to GHS
☐ Cytogenetics sent to CSI

☐ **Core in RPMI sent to CSI for "culture & hold". Please let send out dept know which test you would like to have performed.**

Testing Requested:

☐ **Complex Complete Exam**
With any medically necessary ancillary studies as directed by the pathologist based on clinical information & morphologic findings. These may include flow cytometry, cytogenetics, and/or molecular studies.
☐ If specific testing is required/requested regardless of the diagnosis (such as for clinical trials) please mark below:
☐ **Karyotpye: ☐ FISH (please specify) ☐ FLT3 ☐ IDH1/IDH2 ☐ NPM1**
☐ **Flow Cytometry: ☐ CD25 ☐ CD22 ☐ other (specify antibody or diagnosis)** _____
Default testing includes karyotype & flow cytometry. These will be cancelled if no pathologic abnormality is identified prior to their completion.