LabPMM®
an invivoscribe company

Test Requisition Form

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San Diego, CA 92121
Phone: 858.224.6650
Fax: 858.224.6655
www.invivoscribe.com/clinical-services

PATIENT INFORMATION

*REQUIRED INFORMATION

Last Name*:

First Name*:

MI:

Date of Birth*: | Sex*: M / F

Client Medical Record #:

Client Specimen #/Accession #

Place patient label here if desired

PHYSICIAN & CLIENT INFORMATION

*REQUIRED INFORMATION

Physician*:

Main Contact:

Phone #:

Fax #:

Department:

Institution Name*:

Address:

City: | State: | Zip:

SPECIMEN INFORMATION

Collection Date*: DD / MM / YYYY

Specimen Type*:

❍ Blood (Ship at 4°C or ambient)

❍ Bone Marrow (Ship at 4°C or ambient)

❍ DNA

DNA isolated from: ❍ Blood ❍ Bone Marrow

DNA isolated Date:

PLEASE CHECK THE TEST(S) REQUESTED BELOW

❍ CHECK IF NY PATIENT

❍ *FLT3* ITD & TKD mutation detection by PCR
  ❒ ITD only

❍ *NPM1* mutation detection by PCR

❍ AML mutation panel: *FLT3* & *NPM1* mutation detection by PCR

❍ *FLT3* ITD-SR & TKD mutation detection by PCR (signal ratio)
  ❒ ITD-SR only

❍ AML-SR mutation panel: *FLT3*-SR & *NPM1* mutation detection by PCR (ITD-signal ratio)

❍ MyAML® NGS panel (Not for NY patients for NGS assays)

❍ *FLT3* ITD MRD NGS Assay (Not for NY patients for NGS assays)*

❍ *NPM1* MRD NGS Assay*

*EDTA recommended for MRD Assays

LABPMM USE ONLY

Date Received:

Received By:

Time Received:

Anticoagulant & Volume:

LabPMM Label

LABPMM USE ONLY - COMMENTS