LeukoStrat® CDx *FLT3* Mutation Assay Test Requisition Form

This test is for both *FLT3* ITD and TKD mutations.

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San Diego, CA 92121-2711
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PHYSICIAN & CLIENT INFORMATION *REQUIRED INFORMATION

Main Contact:

Physician*:

Phone #:

Fax #:

Department:

Institution Name*:

Address:

City:	State:	Zip:

SPECIMEN INFORMATION

Collection Date*: DD / MM / YYYY

Specimen Type*:

❍ Blood (in **sodium heparin** only)

❍ Bone marrow (in **sodium heparin** only)

SHIPPING INFORMATION

- Ship all specimens to the address above using an overnight delivery service.
- Samples are received by the laboratory Monday-Saturday.
- Follow all Federal and State regulations when shipping patient samples.
- Please refer to IATA Dangerous Goods Regulations for specific details. (Do not ship LabPMM any specimen defined as a Category A Biological Substance, these shipments will be returned.)
- Ship all specimens ambient or cool; do not freeze. Samples must be received within 7 days of collection.

If there are any questions on shipping please contact the laboratory.

PATIENT INFORMATION *REQUIRED INFORMATION

❑ Check for New York State Patient

Last Name*:

First Name*:	MI:
Date of Birth*:	Sex*: M / F

ICD-10 Code:

Leukemia Diagnosis:

Client Medical Record #:

Client Specimen #/Accession #:

Place patient label here if desired

LABPMM USE ONLY

Date Received:

Received By:

Time Received:

Anticoagulant & volume:

LabPMM Label