LabPMM®
an invivoscribe company

Test Requisition Form

10222 Barnes Canyon Road, Building 1
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*:

Specimen Type (Ship at 4°C or ambient)

❍ Blood

❍ Bone Marrow

❍ DNA[1] isolated from:

❍ Blood ❍ Bone Marrow

Isolation Date:

[1]DNA Extraction must have been performed at a CLIA certified lab

PLEASE CHECK THE TEST(S) REQUESTED BELOW

❍ CHECK IF NEW YORK (NY) PATIENT

❍ LeukoStrat CDx *FLT3* Mutation Assay

❍ *NPM1* mutation detection by PCR

❍ *FLT3* ITD MRD NGS Assay[2,3]

❍ *NPM1* MRD NGS Assay[2,3]

[2]EDTA recommended for MRD Assays; [3]NGS assays are not available for NY patients.

LABPMM USE ONLY

Date Received:

Received By:

Time Received:

Anticoagulant & Volume:

LabPMM Label

LABPMM USE ONLY - COMMENTS