

Important Notice: LabPMM is not enrolled in the Medicare program and is unable to bill Medicare (or Medicare supplemental insurance) for any laboratory tests, including those that meet the Medicare criteria set forth in the "Laboratory Date of Service for Clinical Laboratory and Pathology Specimens" regulation (42 CFR Section 414.510(b)(5)).

By submitting this Test Requisition Form, the ordering entity represents and warrants that the specimen is not for a Medicare patient and acknowledges and agrees that LabPMM will not refund any payment made to LabPMM in the event the entity submits a Medicare patient specimen in error.

PATIENT INFORMATION <small>*REQUIRED INFORMATION</small>		FOR NEW YORK RESIDENTS:	
Last Name*:		<input type="checkbox"/> CHECK IF NEW YORK (NY) PATIENT	
First Name*:			
MI:			
Date of Birth*:	Sex*: M / F		
Client Medical Record #:			
Client Specimen #/Accession #			
<div style="border: 1px solid black; padding: 20px; width: fit-content; margin: 0 auto;"> Place patient label here if desired </div>		PLEASE CHECK THE TEST(S) REQUESTED BELOW:	
		Standard <input type="checkbox"/> LeukoStrat CDx <i>FLT3</i> Mutation Assay <input type="checkbox"/> <i>NPM1</i> Mutation Detection by PCR <input type="checkbox"/> B-cell Clonality (<i>IGH</i>) NGS Assay ⁴	Target TAT 2-3 business days 1-3 business days 12-14 business days
		Measurable Residual Disease (MRD) Tests <input type="checkbox"/> <i>FLT3</i> ITD MRD NGS Assay ^{4,5,6} <input type="checkbox"/> <i>NPM1</i> MRD NGS Assay ^{4,5,6} <input type="checkbox"/> B-cell MRD Assay ^{4,5}	Target TAT 7-10 business days 7-10 business days 14-21 business days
PHYSICIAN INFORMATION <small>*REQUIRED INFORMATION</small>		LABPMM USE ONLY	
Physician*:		Date Received:	
Institution Name*:		Received By:	
Department:		Time Received:	
Phone #:		Anticoagulant and Volume:	
Fax #:		<div style="border: 1px solid black; padding: 20px; width: fit-content; margin: 0 auto;"> LabPMM Label </div>	
Address:			
City:	State:	Zip:	
PRIMARY CONTACT INFORMATION <small>*REQUIRED INFORMATION</small>		LABPMM USE ONLY - COMMENTS	
Name*:			
Phone #:			
Email*:			
Fax #:			
SPECIMEN INFORMATION ¹			
Collection Date*:			
Specimen Type (Ship at 4°C or ambient)			
<input type="checkbox"/> Blood			
<input type="checkbox"/> Bone Marrow ²			
<input type="checkbox"/> DNA ³ isolated from:			
<input type="checkbox"/> Blood <input type="checkbox"/> Bone Marrow			
Isolation Date:			

¹If less than 20 µg DNA is provided, the sensitivity of the assay may be impacted. | ²Ambient bone marrow may limit the sensitivity that can be achieved. | ³DNA Extraction must have been performed at a CLIA certified lab. | ⁴NGS assays are not available for NY patients. | ⁵EDTA recommended for MRD Assays. | ⁶Diagnostic or baseline sample not required.