

**FLOW CYTOMETRY CLINICAL TESTING SERVICE
SPECIAL HEMATOLOGY LABORATORY
THE MILTON S. HERSHEY MEDICAL CENTER
P.O. BOX 850
HERSHEY, PA 17033
(717) 531-8559**

PATIENT INFORMATION

NAME _____

BIRTH DATE _____

SEX: ___ Male ___ Female

COLLECTION DATE _____ TIME _____

Specimens received 7 a.m. Monday thru noon Friday or day before holiday.

REFERRING PHYSICIAN INFORMATION

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE # _____

FAX# _____

HOSPITAL INFORMATION

NAME _____

CONTACT PERSON _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE # _____

FAX# _____

DIAGNOSIS UNDER CONSIDERATION

- _____ Chronic granulocytic leukemia (205·10)
 _____ blast crisis (205·0)
- _____ Acute granulocytic leukemia (205·00)
- _____ Chronic lymphocytic leukemia (204·10)
- _____ Non-Hodgkin's lymphoma (202·80)
- _____ Immunodeficiency (279·3)
- _____ AIDS/HIV Infection (044·9)
- _____ Other _____

TEST(S) REQUESTED

- _____ Lymphocyte Subset Analysis
- _____ Helper/Suppressor Analysis
- _____ Leukemia Phenotype Analysis
 _____ % Blasts in specimen submitted
- _____ Lymphoma Phenotype Analysis
- _____ Cell Surface Kappa/Lambda light chain analysis

- _____ Physician Interpretation

TYPE OF SPECIMEN

- _____ Blood _____ Bone Marrow
- _____ Lymph Node
- _____ Other Tissue/Fluid
 Specify _____

CBC & DIFFERENTIAL

- _____ WBC _____ % Poly _____ % Baso
- _____ Hct _____ % Band _____ % Blast
- _____ Hgb _____ % Lymph
- _____ plt _____ % Eos

PATIENT HISTORY/COMMENTS

- _____ New Diagnosis
- _____ Relapse

PENNSSTATE



College of Medicine
University Hospital · Children's Hospital
The Milton S. Hershey Medical Center

See Reverse For Billing/Insurance Information

COMPLETE THE FOLLOWING FOR BILLING

PARTY TO BE BILLED:

Hospital
(All Inpatients)

Patient
(Complete Lines 1 & 2)

Insurance
(Complete Lines 1 & 2 plus
appropriate insurance lines)

NAME: Responsible Party Subscriber Name **PHONE:** Home Work

1.

RESPONSIBLE PARTY ADDRESS: City State Zip

2.

MEDICAID Medicaid No. State Provider No. Diagnosis & Code No.

MEDICARE Medicare No. & Letter Requesting UPIN No. Railroad Medicare Letter & No. Requesting UPIN No.
 Primary
 Secondary

BLUE CROSS/BLUE SHIELD Policy No. Plan Code Group No. BS State: Relationship to Patient
 Primary Self Child Spouse Other
 Secondary

COMMERCIAL INSURANCE Company's Name Address:
 Primary
 Secondary Policy No. Group No. Relationship to Patient: Self Child Spouse Other

Please attach copy of appropriate authorization form: PCP Referral

I authorize the release of any medical information necessary to process the claim and request payment benefits be made to Hershey Medical Center.

Patient or Authorized Signature