

Flow Cytometry Requisition

Date:	Patient Name:
Referring Institution:	Date of Birth:
Address:	Address:
Referring Physician:	Sex:
Phone: FAX:	Social Security #:
Referring Pathologist:	Clinical History:
Phone:	
FAX:	
Specimen Type:	
Collection Time:	Presumptive Dx:
Collection Date:	

TESTS REQUESTED	
_____	Flow Cytometry Immunophenotyping
_____	T Cells (Ratio)*
_____	T Cells (Complete)*
_____	Other _____
* These tests require a same-day CBC with differential.	

Special Remarks:

Questions: Please call Hematopathology @ 919-966-6938.