Children's Hospital Los Angeles
Alexander R. Judkins, MD
Department of Pathology & Laboratory Medicine
Pathologist–in-Chief and Laboratory Director
4650 Sunset Boulevard
Los Angeles, CA 90027
Phone: 323.361.2423, 877.543.9522
Fax: 323.361.6157
CLIA Number: 05D0542989
California State License CLF260
CAP Number: 2266301

INSTITUTIONAL ACCOUNT

Ship To:

Department of Pathology and Laboratory Medicine
Children's Hospital Los Angeles
4650 Sunset Blvd.
Duque Bldg., 2nd Floor, Room 2-290
Los Angeles, CA 90027

MRD BY FLOW CYTOMETRY TEST REQUISITION

All information must be completed before sample can be processed.

PATIENT INFORMATION

_______________________________, _________________________ _______
Last Name First Name MI

DOB (MM/DD/YYYY): ______________________ Gender: ☐ M ☐ F ☐ Unknown

MRN/ ID Number: ____

CLINICAL INFORMATION

Clinical diagnosis or Indication for test: _________________________________

____

Therapy given: ____

☐ ICD-10 Code: _________________________________

RELEVANT TREATMENT HISTORY

- ☐ Pretreatment
- ☐ End of Induction
- ☐ End of Consolidation
- ☐ Pre-transplant
- ☐ Post-transplant, Day _______
- ☐ Other ___________________
- ☐ Anti-CD19 Therapy (Blinatumumab, CART, etc.)
- ☐ Anti-CD20 Therapy (Rituxumab, etc.)
- ☐ Anti-CD22 Therapy (Inotuzumab, CART, etc.)
- ☐ Anti-CD38 Therapy (Daratumumab, etc.)

SAMPLE INFORMATION

Date of Collection (MM/DD/YYYY):____________________________________

Time Collected: __________ ☐AM ☐PM

Specimen Type:

☐ Blood (EDTA or EDTA in Shipping Media)

☐ Bone Marrow (Sodium Heparin, EDTA or EDTA in Shipping Media)

☐ CSF - (Send refrigerated in Transfix strongly preferred or 1:1 RPMI by volume)

☐ Other (Please Specify) _________________

TEST(S) REQUESTED

Please include report with diagnostic Immunophenotype

☐ **B-ALL MRD by Flow Cytometry, (COG)**

- ☐ Day 8 (peripheral blood)
- ☐ End of Induction - Day 29 (bone marrow)
- ☐ Other, e.g. End of Consolidation (bone marrow)

NOTE: If the time point is not specified as Day 8 or End of Induction, testing will include additional evaluation for CD19 negative leukemia.

☐ **T-ALL MRD by Flow Cytometry**

☐ **AML MRD by Flow Cytometry**

- ☐ Megakaryoblastic

☐ **MPAL MRD by Flow Cytometry (specify lineages)**

☐ B lineage ☐ T lineage ☐ Myeloid lineage

☐ **CRLF2 evaluation by Flow Cytometry with reflex to CRLF2 FISH if positive**

☐ **Other by Flow Cytometry (specify)** ________________________________

REPORTING INFORMATION

Hospital/Laboratory Name: University of Missouri Hospital Pathology

Ordering Physician: ____

Contact Number: ____

Address: 1 Hospital Drive, Room L2004

City: Columbia State: MO Zip Code: 65212

Phone: (573) 884-5556 Secure Fax: (573) 884-0032

☐ Send Duplicate Report to:

Physician: ____

NPI: ____

Address: ____

City: ___________________________ State: ________ Zip Code: ____________

BILLING INFORMATION

PLEASE NOTE: We only bill the submitting institution. We do not bill third parties.

Referring Institution

CHLA Account Number* : **1796**

Hospital/Laboratory Name: University of Missouri Hospital Pathology

Address: 1 Hospital Drive, Room L2004

City: Columbia State: MO Zip Code: 65212

Accounts Payable Contact Name: Cody Buxton

Phone: (573) 884-5556 Fax: (573) 884-0032

Email: buxtonce@health.missouri.edu

*See reverse side to open an account with CHLA Laboratory.

SEE PAGE 2 FOR SAMPLE REQUIREMENTS AND SHIPPING INSTRUCTIONS.

For Internal Use Only:

Date Received: ______/______/______ Time Received: ______: ______ AM /PM

Technician: ____

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SAMPLE REQUIREMENTS

Each specimen must be labeled with two patient identifiers; patient name or study ID and date of birth. Indicate the specimen type on the tube, either peripheral blood (PB) or bone marrow aspirate (BMA). The patient requisition form must accompany the specimen; the requisition form must contain and match the same two patient identifiers as on the specimen. Note that use of patient name on the specimen tube is not a HIPAA violation.

BONE MARROW COLLECTION

Collect 2 to 3 mL bone marrow aspirate from the first pull and immediately transfer from syringe to either an EDTA or Sodium Heparin tube. Use of shipping media (RPMI + EDTA) can enhance specimen viability. Please do not ship syringes

PERIPHERAL BLOOD COLLECTION

Peripheral blood is drawn into a 5 ml EDTA tube, minimum volume is 2 ml. Mix well. Use of shipping media (RPMI + EDTA) can enhance specimen viability. Please do not ship syringes.

CEREBROSPINAL FLUID

Collect or transfer 1-2ml of CSF directly into a 5 ml Transfix tube, preferably at bedside. Mix and refrigerate. This is the preferred method. Alternatively, CSF can be mixed 1:1 with RPMI by volume and refrigerated. Ship refrigerated for either method to preserve antigenic and cellular integrity.

SHIPPING AND HANDLING INSTRUCTIONS

TEMPERATURE:

All samples should be shipped at ***room temperature*.** Samples shipped during extremely hot weather periods can be packaged with a cold pack (not an ice pack).

GENERAL INSTRUCTIONS:

1. Please make every effort to ship specimens on the day they are collected to maximize cell viability, but specimens that are shipped the following day will also be accepted.
2. We accept samples Monday through Friday from 7:00 AM to 4:00 PM PST. We also accept samples on Saturdays from 7:00 AM to 2:00 PM PST. Holidays and weekends should be taken into consideration before mailing samples.
3. To ensure sample integrity, use of the following delivery priorities is highly recommended.

   FedEx: First Overnight
   UPS: Next Day Air Early AM

4. We will notify you within 24 hours of receipt if we are unable to perform testing due to compromised sample integrity.
5. Please notify us ASAP in writing if you wish to cancel a test. Cancellations cannot be accepted once testing has been initiated.
6. **Your specimen is important to us. Please email the tracking number to PLMTrack@chla.usc.edu at the time of shipment and include contact information to be used in the event your sample is not received.**

BILLING INFORMATION

1. For billing inquiries, please call (877) 543-9522.
2. If you are interested in opening an account with Children's Hospital Los Angeles, please contact our Laboratory Service Center at (877) 543-9522. Please be prepared to provide the following information:
   a. Name of Institution
   b. Address
   c. Phone/Fax Number
   d. Laboratory Contact Name and phone number
   e. Accounts Payable Contact Name and phone number
3. Third party billing is not offered at this time.

CONTACT US

For all other inquiries, please contact our Laboratory Service Center at:

(877)KIDZ-LAB or (877) 543-9522

Visit our website at:

www.chla.org/laboratory-medicine