RUSH MEDICAL LABORATORIES
MOLECULAR DIAGNOSTICS LABORATORIES
FLOW CYTOMETRY LABORATORY
(312)942-8393

PATIENT INFORMATION FORM

Patient's Name: ____

DOB: ______________ **Sex:** __________ **Medical Record #** ________________________

Physician's Name : ____

Hospital (if outside RPSLH): ____________________ **phone #** ____________________

SPECIMEN TYPE:

Bone Marrow Aspirate: **RPIC** ☐ **LPIC** ☐ **Peripheral Blood** ☐

Other (Specify): ____

Date & Time Collected: ____/___/____ ______________**AM/PM**

SUSPECTED DIAGNOSIS: ______________________________

REASON FOR EVALUATION:

Initial W/U ☐ **Restage/Monitor** ☐ **Pre BMT eval** ☐

Suspect change in histology ☐ **Other** ☐ ______________

PREVIOUS TREATMENT:

Systemic Chemotox ☐ **Radiotx** ☐ **IFN** ☐ **BMT** ☐

Cytokine (IL'S) ☐ **Antibodies** ☐ **Other** ☐ __________

NAME OF PERSON FILLING OUT THIS FORM: ______________________ **PHONE #** ________