



**Instructions:** Send the completed form with the patient specimen to avoid delays in testing and ensure appropriate specimens are submitted.

**Patient Information**

Patient Name <i>(Last, First, Middle)</i>	Birth Date <i>(mm-dd-yyyy)</i>	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Referring Provider Name <i>(Last, First)</i>	Phone	Fax*
Other Contact <i>(Last, First)</i>	Phone	Fax*

*\*Fax number given must be from a fax machine that complies with applicable HIPAA regulations.*

**Test Requested**

<input type="checkbox"/> BCLL / IGH Somatic Hypermutation Analysis, B-Cell Chronic Lymphocytic Leukemia (B-CLL), Varies <input type="checkbox"/> P53CA / Hematologic Neoplasms, TP53 Somatic Mutation, DNA Sequencing Exons 4–9 , Varies
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**Specimen Provided**

<input type="checkbox"/> Blood (liquid) <input type="checkbox"/> Bone Marrow Aspirate (liquid) (P53CA / Hematologic Neoplasms, TP53 Somatic Mutation, DNA Sequencing Exons 4–9 , Varies) <input type="checkbox"/> Fresh Tissue (P53CA / Hematologic Neoplasms, TP53 Somatic Mutation, DNA Sequencing Exons 4–9 , Varies), specify type: _____
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**Clinical Information** Required – incomplete information will result in **delayed processing and resulting.**

<input type="checkbox"/> Diagnostic sample <input type="checkbox"/> Posttreatment sample
Provide the following information: <input type="checkbox"/> Flow cytometry report or other diagnostic paperwork indicating confirmation of CLL diagnosis and % of B-cells. <input type="checkbox"/> WBC count from a recent CBC <b>or</b> absolute lymphocyte count: _____ <input type="checkbox"/> Other relevant clinical information: _____