**UNC Department of Pathology and Laboratory Medicine**

# Flow Cytometry Requisition

| | |
|---|---|
| Date: | **Patient Name:** |
| **Referring Institution:** | Date of Birth: |
| Address: | Address: |
| **Referring Physician:** | Sex: |
| Phone: | Social Security #: |
| Fax: | |
| **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 @ 984- 974-8320**