UNC Department of Pathology and Laboratory Medicine

Bone Marrow Processing Requisition

(Marrows should be received in the lab by 2:30 PM for same-day processing.)

Date:	**Patient Name:**
Referring Institution:	Date of Birth:
Address:	Address:
Referring Physician:	Sex:
Phone: FAX:	Social Security #:
Referring Pathologist:	
Phone: FAX:	
Clinical History:	
Presumptive Diagnosis:	

Material Forwarded (***Please send peripheral blood smear and CBC data, if available.***)		
Bone Marrow aspirate:	Left _____	Right _____
Bone Marrow touch preparation:	Left _____	Right _____
Bone Marrow Core biopsy:	Left _____	Right _____

Special Studies requested	
Cytogenetics:	DNA (specify)
Flow Cytometric Immunophenotyping:	Other (specify)

Physician signature _____