Cancer Cytogenetics Requisition

Cytogenetics Laboratory
2330 Inwood Road, Suite EB3.302
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UTSouthwestern Medical Center
CLINICAL LABORATORY SERVICES

ACCOUNT INFORMATION

Account name: _____

Address: _____ **City:** _____ **State:** _____

Zip code: _____ **Ph:** _____ **Fax:** _____

REQUIRED ORDER INFORMATION

BILL TO: ☐ Facility / Client
☐ Patient / 3rd party **– Billing information must be provided**

Patient Name: (Last, First, Middle)

Mother's Name: (if infant)

Date of Birth: | Sex: | Patient ID / MR#:

Hospital Inpatient Y / N | Collection Date: | Collection Time: : AM PM

Ordering Physician (Full Name): | NPI:

Phone: | Pager: | FAX:

Clinical Indication for Tests Ordered:

SPECIMEN INFORMATION

☐ Blood (Submit only if marrow is unobtainable)
☐ Bone Marrow___aspirate___biopsy
☐ Tumor site/type_____
☐ Formalin Fixed Paraffin Embedded Tissue (FFPE):
case:_____block:_____(include external path report)
☐ Other_____

Initial Diagnosis? ☐ No ☐ Yes
S/P Transplant? ☐ No ☐ Yes Donor Sex M / F

PATIENT/3RD PARTY BILLING INFORMATION

ICD-10 Code(s)

Medicare patients with non-covered diagnoses must sign Advanced Beneficiary Notice (ABN) available at www.veripathlabs.com or by calling customer service at 214-645-7057 or toll free 877-887-8136 ☐ Signed ABN included

ICD-10 Codes applicable to each and every test requested should come only from the ordering physician, represent the reason for the test order at the time of order, and be supported by the patient's medical record. Physicians should order only tests that are medically necessary for the diagnosis or treatment of the patient. Tests ordered should be single laboratory tests appropriate for the patient's medical condition. Tests for screening purposes may be ordered, but may not be reimbursed.

Insured/Responsible Party Name: (if different from patient-Last, First, Middle) | Date of Birth:

Patient's relationship: ☐ Self ☐ Spouse ☐ Dependent ☐ Other | Responsible Party Address: (street, city, State, zip)

Sex: | Phone:

Employer's Name: | Employer's Phone:

Insurance Co. Name: | Insurance Co. Phone:

Insurance Co. Address:

Policy #: | Group #:

☐ Medicare ☐ HMO ☐ Other ☐ Medicaid ☐ PPO | Member ID#:

Referral Authorization/Precertification #:

Name: Date/Time:

DIAGNOSTIC INFORMATION

Diagnosis ☐ Confirmed ☐ Suspected

Hematologic disorders:

☐ ALL
☐ AML, FAB type_____
☐ CLL
☐ CML
☐ Cytopenia*
☐ Lymphoma*
☐ Multiple myeloma
☐ Myeloproliferative disorder*
☐ Myelodysplastic disorder*
☐ Other_____

Tumors:

☐ Ewing sarcoma/PNET
☐ Germ cell tumor
☐ Hepatoblastoma
☐ Lymphoma*
☐ Neuroblastoma
☐ Rhabdomyosarcoma
☐ Synovial sarcoma
☐ Wilms tumor
☐ Other_____

***Specify Type/Additional History:** _____

TEST REQUESTED

Check one ➡ ☐ Chromosomal Analysis ☐ Chromosomal Analysis with FISH (Specify FISH below) ☐ FISH only (see below)

FISH Tests:

☐ Aneuploidy of 4/10
☐ Aneuploidy of 8/20q deletion
☐ Aneuploidy of 9/15
☐ ABL1: 9q34
☐ ABL2: 1q25
☐ ALK: 2p23 FFPE
☐ ATM/12cen: 11q22/aneu12
☐ BIRC3/MALT1: t(11;18)
☐ BCL6: 3q27 FFPE
☐ BCR/ABL1: t(9;22)
☐ CBFB: inv(16)
☐ CBFB/MYH11: 16q22/16p13
☐ CCND1/IGH: t(11;14)
☐ C-MET: 7q31.2 FFPE
☐ CRLF2: Xp22/Yp11
☐ D13S319(DLEU): 13q14/13q34
☐ Deletion/monosomy 5
☐ Deletion/mosomony 7
☐ DDIT3: 12q13 FFPE
☐ E2A: 19p13
☐ EGFR: 7p12 FFPE
☐ EGR1: 5q31
☐ ETV6/RUNX1: t(12;21)
☐ EWSR1: 22q12 FFPE
☐ FIP1L1/PDGFRA: 4q12
☐ FGFR1: 8p11
☐ FGFR3/IGH: t(4;14)
☐ FOXO1: 13q14 FFPE
☐ FUS: 16p11 FFPE
☐ HER2/neu: 17q11.2-12 FFPE
☐ IGH BA: 14q32
☐ IGH/BCL2: t(14;18) FFPE
☐ IGH/MAF: t(14;16)
☐ IGH/MAFB: t(14;20)
☐ MDM2: 12q15 FFPE
☐ MECOM: 3q26
☐ MLL (KMT2A): 11q23
☐ MYB: 6q23.3
☐ MYC BA: 8q24 FFPE
☐ MYC/IGH t(8;14) FFPE
☐ MYCN: 2p23-24 FFPE
☐ NUP98: 11p15
☐ P16: 9p21 FFPE
☐ P18(CKS1B/CDKN2C): 1p32.3/1q21
☐ PDGFRα:4q12
☐ PDGFRβ: 5q33.1
☐ PML/RARA: t(15;17)
☐ RB1: 13q14
☐ REL: 2p16
☐ RET: 10q11.2 FFPE
☐ ROS1: 6q22 FFPE
☐ RUNX1T1/RUNX1: t(8;21)
☐ SS18: 18q11.2 FFPE
☐ TFE-3: Xp11.2 FFPE
☐ TFE-B: 6p21 FFPE
☐ TP53: 17p13.1
☐ UroVysion
☐ Other FISH _____

FISH Panels: ☐ CLL ☐ Multiple Myeloma ☐ MDS ☐ ALL ☐ AML ☐ Lymphoma

Lung Adenocarcinoma Panel (On FFPE Tissue): ☐ ALK ☐ ROS1 ☐ RET ☐ C-MET ☐ HER2

Other FISH (please call lab): _____

Transplant (analysis)
☐ X/Y chromosomes
Donor Sex
☐ male ☐ female