



CANCER/LEUKEMIA REQUISITION FORM

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Nashville, Tennessee 37203
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www.geneticsassociates.com

PATIENT INFORMATION

Name: <i>(Last, First, Middle)</i>	<input type="checkbox"/> Male Birth: / /	<input type="checkbox"/> Female / /	Date of
Address:	Home Phone:	Work Phone:	
City:	State:	Zip:	Lab # Hospital #

REFERRED BY

Physician: <i>(print)</i>	Facility:	Phone:
		Fax Number:
I attest that this patient has been informed and has given consent for the test(s) I have ordered under applicable law.	Address:	
Physician/Authorized Signature: _____	City:	State:
	Zip:	

BILLING

CLIENT BILL * INSURANCE * MEDICARE/MEDICAID SELF-PAY * *Attach billing information*

SPECIMEN INFORMATION (DO NOT FREEZE - ALL SPECIMENS MUST BE LABELED)

Date of Collection: ___/___/___ Time of Collection: _____

Status: Pre-Transplant Post-Transplant

Donor: Male Female Autologous

WBC: _____ Blasts: _____

Bone Marrow
 Bone Core
 Peripheral Blood
 Lymph Node
 Mass/Solid Tumor (Source): _____

Other: _____

Paraffin Slides
Positively charged 3-4µ thick with accompanying marked H & E slide (2 slides per probe minimum)

REFERRING DIAGNOSES (CHECK ALL THAT APPLY)

ICD-10: _____ <input type="checkbox"/> Acute Lymphoblastic Leukemia (ALL) <input type="checkbox"/> Acute Myeloid Leukemia (AML) <input type="checkbox"/> Acute Promyelocytic Leukemia (APL) <input type="checkbox"/> Anemia	<input type="checkbox"/> Chronic Myelogenous Leukemia (CML) <input type="checkbox"/> Chronic Lymphocytic Leukemia (CLL) <input type="checkbox"/> Hairy Cell Leukemia (HCL) <input type="checkbox"/> Hodgkin Lymphoma <input type="checkbox"/> Leukocytosis <input type="checkbox"/> Leukopenia <input type="checkbox"/> MGUS	<input type="checkbox"/> Monoclonal Paraproteinemia <input type="checkbox"/> Multiple Myeloma (MM) <input type="checkbox"/> Myelodysplastic Syndrome (MDS) <input type="checkbox"/> Myeloproliferative Neoplasm (MPN) <input type="checkbox"/> Non-Hodgkin Lymphoma, B-Cell <input type="checkbox"/> Non-Hodgkin Lymphoma, T-Cell <input type="checkbox"/> Pancytopenia	<input type="checkbox"/> Plasma Cell Neoplasm <input type="checkbox"/> Polycythemia <input type="checkbox"/> Thrombocytosis <input type="checkbox"/> Thrombocytopenia <input type="checkbox"/> Other: <i>(Please Specify)</i> _____
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REQUESTED TESTING

<p><input type="checkbox"/> Chromosome Analysis (<i>Karyotype</i>)</p> <p>FISH: (<i>Check all that apply</i>) <input type="checkbox"/></p> <p>Myelodysplastic (MDS) profile</p> <ul style="list-style-type: none"> <input type="checkbox"/> del(5q) EGR1 <input type="checkbox"/> del(7q) / monosomy 7 <input type="checkbox"/> trisomy 8 <input type="checkbox"/> del(20q) <p>Additional probes</p> <ul style="list-style-type: none"> <input type="checkbox"/> 11q23 KMT2A (MLL) rearrangements <input type="checkbox"/> t(9;22) BCR/ABL1/ASS1 <input type="checkbox"/> NUP98 11p15 <p>Myeloproliferative (MPN) profile</p> <ul style="list-style-type: none"> <input type="checkbox"/> del(5q) EGR1 <input type="checkbox"/> del(7q) / monosomy 7 <input type="checkbox"/> trisomy 8 <input type="checkbox"/> del(20q) <input type="checkbox"/> t(9;22) BCR/ABL1/ASS1 <p>Additional probes</p> <ul style="list-style-type: none"> <input type="checkbox"/> 4q12 FIP1L1/CHIC2/PDGFR <input type="checkbox"/> 5q32 PDGFRB rearrangements <input type="checkbox"/> 8p11 FGFR1 rearrangements <input type="checkbox"/> 9p24 JAK2 rearrangements <p>Acute Myelogenous (AML) profile</p> <ul style="list-style-type: none"> <input type="checkbox"/> t(15;17) PML/RARA <input type="checkbox"/> t(9;22) BCR/ABL1/ASS1 <input type="checkbox"/> t(8;21) RUNX1T1/RUNX1 <input type="checkbox"/> 11q23 KMT2A (MLL) rearrangements <input type="checkbox"/> inv(16), t(16;16) CBFβ rearrangements <input type="checkbox"/> inv(3) MECOM rearrangements <input type="checkbox"/> 17q RARA rearrangements <input type="checkbox"/> NUP98 11p15 <p>Chronic Myelogenous (CML) profile</p> <ul style="list-style-type: none"> <input type="checkbox"/> t(9;22) BCR/ABL1/ASS1 <p>Additional probes</p> <ul style="list-style-type: none"> <input type="checkbox"/> trisomy 8 <input type="checkbox"/> i(17q) 	<p><input type="checkbox"/> CD19+ clones (<i>Please select below</i>)</p> <p>Chronic Lymphocytic (CLL) profile</p> <ul style="list-style-type: none"> <input type="checkbox"/> del(11q) ATM <input type="checkbox"/> trisomy 12 <input type="checkbox"/> del(13q) 13q14/13q34 <input type="checkbox"/> del(17p) TP53 <p>Additional probes</p> <ul style="list-style-type: none"> <input type="checkbox"/> t(11;14) CCND1/IGH <input type="checkbox"/> del(6q) CCND3/SEC63/MYB <p>Pediatric ALL profile</p> <ul style="list-style-type: none"> <input type="checkbox"/> t(12;21) ETV6/RUNX1 <input type="checkbox"/> 11q23 KMT2A (MLL) rearrangements <input type="checkbox"/> t(9;22) BCR/ABL1/ASS1 <input type="checkbox"/> trisomy 4,10,17 <input type="checkbox"/> 14q32 IGH rearrangements <p>Additional probes</p> <ul style="list-style-type: none"> <input type="checkbox"/> t(1;19) TCF3/PBX1 <p>Adult B-Cell ALL profile</p> <ul style="list-style-type: none"> <input type="checkbox"/> del(9p) CDKN2A <input type="checkbox"/> del(6q) CCND3/SEC63/MYB <input type="checkbox"/> t(9;22) BCR/ABL1/ASS1 <input type="checkbox"/> 11q23 KMT2A (MLL) rearrangements <input type="checkbox"/> t(1;19) TCF3/PBX1 <input type="checkbox"/> 14q32 IGH rearrangements <p>Ph Like ALL profile</p> <ul style="list-style-type: none"> <input type="checkbox"/> 1q25.2 ABL2 <input type="checkbox"/> 5q32 PDGFRB <input type="checkbox"/> 5q32 CSF1R <input type="checkbox"/> 9p24.1 JAK2 <input type="checkbox"/> 9q34.1 ABL1 <input type="checkbox"/> 19p13.2 EPOR <input type="checkbox"/> Xp22.33/Yp11.3 CRLF2 	<p>Adult T-Cell ALL profile</p> <ul style="list-style-type: none"> <input type="checkbox"/> 14q11.2 TRA rearrangements <input type="checkbox"/> 7q34 TRB rearrangements <input type="checkbox"/> 10q24 TLX1 <input type="checkbox"/> 5q35 TLX3 <input type="checkbox"/> 11q23 KMT2A (MLL) rearrangements <input type="checkbox"/> del(9p) CDKN2A <p>T-cell Leukemia/Lymphoma probes</p> <ul style="list-style-type: none"> <input type="checkbox"/> 2p23 ALK (Anaplastic) rearrangements <input type="checkbox"/> 14q11.2 TRA rearrangements <input type="checkbox"/> 7q34 TRB rearrangements <input type="checkbox"/> i(7q) 7cen/7q22/7q31 <input type="checkbox"/> 14q32 TCL1A <input type="checkbox"/> 10q24 TLX1 <input type="checkbox"/> 5q35 TLX3 <p>Multiple Myeloma CD138 Enriched (MM) profile (FISHnet™)</p> <ul style="list-style-type: none"> <input type="checkbox"/> 1p32.3/1q21 CDKN2C/CKS1B <input type="checkbox"/> del(13q) 13q14/13q34 <input type="checkbox"/> del(17p) TP53 <input type="checkbox"/> t(11;14) CCND1/IGH <input type="checkbox"/> t(4;14) FGFR3/IGH <input type="checkbox"/> t(14;16) IGH/MAF <p>Additional probes</p> <ul style="list-style-type: none"> <input type="checkbox"/> trisomy 5 <input type="checkbox"/> 8q24 MYC rearrangements <input type="checkbox"/> t(6;14) CCND3/IGH <input type="checkbox"/> t(14;20) IGH/MAFB 	<p><input type="checkbox"/> CD19+ clones (<i>Please select below</i>)</p> <p>Lymphoma probes</p> <ul style="list-style-type: none"> <input type="checkbox"/> t(8;14) MYC/IGH (Burkitt or Follicular) <input type="checkbox"/> 8q24 MYC rearrangements <input type="checkbox"/> t(11;14) CCND1/IGH (Mantle Cell) <input type="checkbox"/> t(11;18) BIRC3/MALT1 <input type="checkbox"/> 18q21 BCL2 rearrangements <input type="checkbox"/> 18q21 MALT1 rearrangements <input type="checkbox"/> t(14;18) IGH/BCL2 (Follicular or Diffuse Large B-Cell) <input type="checkbox"/> 3q27 BCL6 rearrangements (Diffuse Large B-Cell, Follicular, Marginal Zone B-cell) <p>Solid Tumor probes</p> <ul style="list-style-type: none"> <input type="checkbox"/> EWSR1 Ewing Sarcoma <input type="checkbox"/> FOXO1 Alveolar Rhabdomyosarcoma <input type="checkbox"/> DDIT3 (CHOP) Myxoid Liposarcoma <input type="checkbox"/> LOH 1p/19q Glioma <input type="checkbox"/> MYCN 2p24.1 Neuroblastoma <input type="checkbox"/> SS18 Synovial Sarcoma <input type="checkbox"/> UroVysion® <p>Transplant</p> <ul style="list-style-type: none"> <input type="checkbox"/> XX/XY for sex mismatched transplants <input type="checkbox"/> FISH for known abnormalities <p>Other: _____</p> <p>See Molecular/Microarray Requisition for all molecular testing.</p>
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SPECIMEN COLLECTION					
Test	Specimen Type	Volume	Container	Storage Conditions	Special Instructions
Chromosome Analysis & FISH	Peripheral Blood	Adult/Child: 2-5 mL Newborn: 1-2 mL	Sodium Heparin Green-top Tube	Room Temperature	Do Not Freeze
	Bone Marrow	Adult/Child: 2-5 mL Newborn: 1-2 mL	Sodium Heparin Green-top Tube	Room Temperature	Do Not Freeze
	Paraffin-embedded Tissue	Positively charged 3-4µ thick, 2 slides per probe minimum	Slide Mailer	Room Temperature	Include H&E Slide Mark Area of Interest
	Solid Tissue Biopsy	Sterile Saline/RPMI Media	Sterile Specimen Cup	Room Temperature or Refrigerate	Do Not Freeze Do Not Add Formalin
	Fine Needle Aspirate	Sterile Saline/RPMI Media	Sterile Centrifuge Tube with RPMI	Room Temperature	Do Not Freeze Do Not Add Formalin
	Pleural Fluid	Whole Fluid	Sterile Centrifuge Tube 15-50 mL	Room Temperature	Do Not Freeze
	Urine	≥33 mL	Mix the urine at a 2:1 ratio with either Carbowax or PreservCyt.	Refrigerate	Do Not Freeze
PCR	Bone Marrow	Adult/Child: 2-5 mL	EDTA Purple-top Tube	Refrigerate immediately	Do Not Freeze Specimen Must be received in lab within 48 hours of collection

Peripheral Blood	Adult/Child: 2-5 mL	EDTA Purple-top Tube	Refrigerate immediately	Do Not Freeze Specimen Must be received in lab within 48 hours of collection
Paraffin-embedded Tissue	Positively charged 3-4 μ thick, 4 Slide Minimum	Slide Mailer	Room Temperature	Include H&E Slide Mark Area of Interest

SPECIMEN COLLECTION AND TRANSPORTATION

- Clearly label each specimen with patient name and one other unique identifier such as date of birth or medical record number.
- Call Genetics Associates, Inc. at 615-327-4532 for pick-up in the greater Nashville area.
- Federal Express overnight shipment will be provided for all outlying areas.
- Whenever there is a sample to be shipped on Friday, please be sure to mark the "Saturday Delivery" box on the FedEx air bill.
- Please send samples with a cool pack to ensure specimen integrity.
- **Please refer to the Genetics Associates website for complete specimen collection guide.**
www.geneticsassociates.com

PATIENT BILLING INFORMATION

PLEASE INCLUDE A COPY OF THE PATIENT'S FACE SHEET PLUS A COPY OF THE INSURANCE CARD(S) FOR BILLING PURPOSES.

CLIENT BILL

INSURANCE

MEDICARE/MEDICAID

SELF-PAY

USE OF SPECIMENS

Genetics Associates Inc. may retain patient samples (specimens) for validation, educational purposes and/or research. All patient information is maintained as confidential and secure. Any patient samples which are retained by Genetics Associates, Inc. are de-identified and all individually identifiable patient information is removed before samples are used for research.

By marking the box below, you may decline research use and it will not impact the services to you by Genetic Associates, Inc. diagnostic testing/ reports. Unless you mark the box below, you consent to the use of your de-identified patient sample for the limited purposes described above.

I am checking this box to indicate that the sample may **NOT** be used for validation, educational purposes and/or research. Patient initials: _____

My Address is _____

My Telephone Number is _____ My email address is _____

Signature of Patient /Responsible Party (Required) _____ Date (Required) _____

Relationship to Patient (Required) _____