GENETICS ASSOCIATES INCORPORATED
www.geneticsassociates.com

MOLECULAR/MICROARRAY REQUISITION FORM

1916 Patterson Street, Suite 400
Nashville, Tennessee 37203
Phone: 615-327-4532
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PATIENT INFORMATION

Name: *(Last, First, Middle)*	□ Male □ Female	Date of Birth: / /
Address:	Home Phone:	Work Phone:
City: State: Zip:	Lab #	Hospital #

REFERRED BY

Physician: *(print)*	Facility: Phone:
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

□ Bone Marrow □ Peripheral Blood

WBC:_____ Blasts:_____

REFERRING DIAGNOSES *(CHECK ALL THAT APPLY)*

ICD-10: _____

□ Acute Lymphoblastic Leukemia (ALL)
□ Acute Myeloid Leukemia (AML)
□ Acute Promyelocytic Leukemia (APL)
□ Anemia
□ Chronic Myelogenous Leukemia (CML)
□ Chronic Lymphocytic Leukemia (CLL)
□ Hairy Cell Leukemia (HCL)
□ Hodgkin Lymphoma
□ Leukocytosis
□ Leukopenia
□ MGUS
□ Monoclonal Paraproteinemia
□ Multiple Myeloma (MM)
□ Myelodysplastic Syndrome (MDS)
□ Myeloproliferative Neoplasm (MPN)
□ Non-Hodgkin Lymphoma, B-Cell
□ Non-Hodgkin Lymphoma, T-Cell
□ Pancytopenia
□ Plasma Cell Neoplasm
□ Polycythemia
□ Thrombocytosis
□ Thrombocytopenia
□ Other: *(Please Specify)*
_____

REQUESTED TESTING

QUANTITATIVE PCR:

□ **BCR-ABL1 p210 t(9;22)**
□ **BCR-ABL1 p190 t(9;22)**
□ **JAK2 V617F**

QUALITATIVE PCR:

□ **FLT3 Mutation Detection**
□ **T-cell Clonality Assessment**
□ **B-Cell Clonality Assesment**
□ **IgVH Hypermutation Analysis**
□ **Thrombophilia Panel** (Factor II, Factor V, MTHFR)

NEXT-GENERATION SEQUENCING:

□ **Myeloid Complete Molecular Profile** (ABL1, ASXL1, BRAF, CALR, CBL, CEBPA, CSF3R, DNMT3A, EZH2, IDH1, IDH2, JAK2, KIT, KRAS, MPL, NPM1, NRAS, RUNX1, SETBP1, SF3B1, SRSF2, TET2, TP53, U2AF1)

For FLT3 mutation analysis, please select the box under "Qualitative PCR" (See Above)

□ **MDS Molecular Profile** (ASXL1, EZH2, DNMT3A, RUNX1, SF3B1, SRSF2, TET2, TP53, U2AF1)

□ **MPN Molecular Profile** (ABL1, CALR, CSF3R, EZH2, JAK2, MPL, SETBP1)

□ **AML Molecular Profile** (ASXL1, CBL, CEBPA, CSF3R, DNMT3A, EZH2, IDH1, IDH2, JAK2, KIT, MPL, NPM1, NRAS, RUNX1, SETBP1, SF3B1, SRSF2, TET2, TP53, U2AF1)

For FLT3 mutation analysis, please select the box under "Qualitative PCR" (See Above)

□ CANCER MICROARRAY

Preferred test for detecting DNA copy number changes and loss of heterozygosity (LOH) in leukemias/lymphomas at time of diagnosis.

SPECIMEN COLLECTION

Specimen Type	Volume	Container	Storage Conditions	Special Instructions
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: 5-10 mL	EDTA Purple-top Tube	**Refrigerate immediately** ***Do Not Freeze***	**Specimen Must be received in lab within 48 hours of collection**

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.
- If 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 www.geneticsassociates.com for a complete specimen collection guide.**

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)**