

CANCER/LEUKEMIA REQUISITION FORM

PATIENT INFORMATION			
Name: <i>(Last, First, Middle)</i>		<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth: / /
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			
<input type="checkbox"/> CLIENT BILL	<input type="checkbox"/> INSURANCE	* Attach billing information including a copy of the patient's face sheet plus a copy of the insurance card(s) for billing purposes.	
<input type="checkbox"/> SELF-PAY	<input type="checkbox"/> MEDICARE/MEDICAID		
SPECIMEN INFORMATION (DO NOT FREEZE - ALL SPECIMENS MUST BE LABELED)			
Date of Collection: _____ Time of Collection: _____		<input type="checkbox"/> Bone Marrow	<input type="checkbox"/> Fixed Pellets (Bone Marrow & Leukemic Blood)
Status: <input type="checkbox"/> Pre-Transplant <input type="checkbox"/> Post-Transplant		<input type="checkbox"/> Bone Core	<input type="checkbox"/> Other: _____
Donor: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Autologous		<input type="checkbox"/> Peripheral Blood	<input type="checkbox"/> Paraffin Slides
WBC: _____ Blasts: _____		<input type="checkbox"/> Lymph Node	Positively charged 3-4µ thick with accompanying marked H & E slide (2 slides per probe minimum)
		<input type="checkbox"/> Mass/Solid Tumor (Source): _____	
REFERRING DIAGNOSES (CHECK ALL THAT APPLY)			
ICD-10: _____		<input type="checkbox"/> Chronic Myelogenous Leukemia (CML)	<input type="checkbox"/> Monoclonal Paraproteinemia
<input type="checkbox"/> Acute Lymphoblastic Leukemia (ALL)	<input type="checkbox"/> Chronic Lymphocytic Leukemia (CLL)	<input type="checkbox"/> Hairy Cell Leukemia (HCL)	<input type="checkbox"/> Multiple Myeloma (MM)
<input type="checkbox"/> Acute Myeloid Leukemia (AML)	<input type="checkbox"/> Hodgkin Lymphoma	<input type="checkbox"/> Leukocytosis	<input type="checkbox"/> Myelodysplastic Syndrome (MDS)
<input type="checkbox"/> Acute Promyelocytic Leukemia (APL)	<input type="checkbox"/> Leukopenia	<input type="checkbox"/> Anemia	<input type="checkbox"/> Myeloproliferative Neoplasm (MPN)
	<input type="checkbox"/> MGUS		<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>
REQUESTED TESTING			
<input type="checkbox"/> Chromosome Analysis (Karyotype) <input type="checkbox"/> FISH: (Check all that apply) Adult B-Cell ALL profile <input type="checkbox"/> del(9p) CDKN2A <input type="checkbox"/> del(6q) 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 Adult T-Cell ALL profile <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 Pediatric ALL profile (COG) <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 Additional probes <input type="checkbox"/> t(1;19) TCF3/PBX1 Ph Like ALL profile <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	Adult AML profile <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 Pediatric AML profile (COG) <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 <input type="checkbox"/> CD19+ clones (Please select below) Chronic Lymphocytic (CLL) profile <input type="checkbox"/> del(11q) ATM <input type="checkbox"/> trisomy 12 <input type="checkbox"/> del(13q) 13q14/13q34 <input type="checkbox"/> del(17p) TP53 Additional probes <input type="checkbox"/> t(11;14) CCND1/IGH <input type="checkbox"/> del(6q) MYB Chronic Myelogenous (CML) profile <input type="checkbox"/> t(9;22) BCR/ABL1/ASS1 Additional probes <input type="checkbox"/> trisomy 8 <input type="checkbox"/> i(17q) Other: _____	<input type="checkbox"/> CD19+ clones (Please select below) Lymphoma probes <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) T-cell Leukemia/Lymphoma probes <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)/monosomy 7 (7cen/7q22/7q31) <input type="checkbox"/> 14q32 TCL1A <input type="checkbox"/> 10q24 TLX1 <input type="checkbox"/> 5q35 TLX3 Myelodysplastic (MDS) profile <input type="checkbox"/> del(5q) EGR1 <input type="checkbox"/> del(7q) <input type="checkbox"/> trisomy 8 <input type="checkbox"/> del(20q) Additional probes <input type="checkbox"/> 11q23 KMT2A (MLL) rearrangements <input type="checkbox"/> t(9;22) BCR/ABL1/ASS1 <input type="checkbox"/> NUP98 11p15 <input type="checkbox"/> 12p13 ETV6 rearrangements See Molecular/Microarray Requisition for all molecular testing.	Multiple Myeloma CD138 Enriched (MM) profile (FISHnet™) <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 Additional probes <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 Myeloproliferative (MPN) profile <input type="checkbox"/> del(5q) EGR1 <input type="checkbox"/> del(7q) <input type="checkbox"/> trisomy 8 <input type="checkbox"/> del(20q) <input type="checkbox"/> t(9;22) BCR/ABL1/ASS1 Additional probes <input type="checkbox"/> 4q12 FIP1L1/CHIC2/PDGFRα <input type="checkbox"/> 5q32 PDGFRB rearrangements <input type="checkbox"/> 8p11 FGFR1 rearrangements <input type="checkbox"/> 9p24 JAK2 rearrangements Solid Tumor probes <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 (SYT) <input type="checkbox"/> Bladder Cancer Screen (Trisomy 3, 7, 17, & 9p21 loss) Transplant <input type="checkbox"/> XX/XY for sex mismatched transplants <input type="checkbox"/> FISH for known abnormalities

PATIENT PREPARATION

Refer to collection facility's procedures for patient preparation requirements.

SPECIMEN COLLECTION

Specimen Type	Volume	Container	Storage Conditions	Special Instructions
Bone Marrow	Adult: 2-5 mL Child ≥8 days: 2-5 mL Newborn: 1-2 mL	Sodium Heparin Green Top Tube	Room Temperature: 20-22°C or Refrigerated Temperature: 2-8°C	Do Not Freeze Invert Tube 4-8 Times to Prevent Clots
Fine Needle Aspirate/Lymph Node/Bone Core	Entire Aspirate/ Specimen/Biopsy	Sterile Centrifuge Tube with Sterile Saline or RPMI	Room Temperature: 20-22°C or Refrigerated Temperature: 2-8°C	Do Not Freeze Do Not Add Formalin
Fixed Pellets	Pellet must be visible	Sterile Centrifuge Tube with 3:1 Methanol: Acetic Acid	Room Temperature: 20-22°C or Refrigerated Temperature: 2-8°C	
Paraffin-Embedded Tissue	Positively charged 3-4µ thick, 2 slides per probe minimum	Slide Mailer	Room Temperature: 20-22°C	Include H&E Slide Mark Area of Interest
Peripheral Blood	Adult: 2-5 mL Child ≥8 days: 2-5 mL Newborn: 1-2 mL	Sodium Heparin Green Top Tube	Room Temperature: 20-22°C or Refrigerated Temperature: 2-8°C	Do Not Freeze Invert Tube 4-8 Times to Prevent Clots
Peritoneal/Pleural Fluid	15-50 mL Whole Fluid	Sterile Centrifuge Tube or Sterile Specimen Cup	Room Temperature: 20-22°C or Refrigerated Temperature: 2-8°C	Do Not Freeze
Mass/Tumor	Entire Mass/Tumor	Sterile Specimen Cup with Sterile Saline or RPMI media	Room Temperature: 20-22°C or Refrigerated Temperature: 2-8°C	Do Not Freeze Do Not Add Formalin
Urine	≥33 mL	Sterile Container with Carbowax or PreservCyt.	Refrigerated Temperature: 2-8°C	Do Not Freeze Mix the urine at a 2:1 ratio with preservative

Special Instruction: Tyrosine kinase inhibitors such as Gleevec may decrease mitotic index for chromosome studies.

Isolated or Extracted Nucleic Acid Acceptance Policy: Genetics Associates, Inc. only accepts nucleic acid for clinical testing that was isolated or extracted in a CLIA-certified laboratory or a laboratory meeting equivalent requirements as determined by the CAP and/or the CMS.

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.
- Mark the "Saturday Delivery" box on the FedEx air bill for all samples shipped on Friday.
- Send samples with a cold pack during warmer weather to ensure specimen integrity. (Use frozen cold pack for specimens requesting PCR)
- Refer to the Genetics Associates website for complete specimen collection guide. www.geneticsassociates.com

USE OF SPECIMENS

Genetics Associates Inc. may retain patient samples (specimens) for test development and improvement, internal validation, quality assurance, and training purposes. All patient information is maintained as confidential and secure. All patient samples which are retained by Genetics Associates, Inc. are de-identified and all individually identifiable patient information is removed before samples are used.

Declining the use of remaining samples for test development and improvement, internal validation, quality assurance, and training purposes will not impact the services to you by Genetics Associates, Inc. diagnostic testing/reports.

If the box below is not checked, 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.

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: _____

Signature of Patient /Authorized Representative (Required) _____ Date (Required) _____