GENETICS ASSOCIATES INCORPORATED
www.geneticsassociates.com

# MOLECULAR/MICROARRAY REQUISITION FORM

1916 Patterson Street, Suite 400
Nashville, Tennessee 37203
Phone: 615-327-4532
Fax: 615-327-0464

## 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. Informed consent (Form FC 012.01) is required for specimens collected in State of New York.<br><br>Physician/Authorized Signature: _____ | Address:<br>City: State: Zip: |

## BILLING

□ **CLIENT BILL** *□ **INSURANCE**
□ **SELF-PAY** *□ **MEDICARE/MEDICAID**

**** Attach billing information including a copy of the patient's face sheet plus a copy of the insurance card(s) for billing purposes.***

## 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:_____

□ Amniotic Fluid
□ Bone Marrow
□ Chorionic Villi
□ Extracted DNA
□ Fixed Pellets
□ Peripheral Blood
□ Products of Conception
□ Tissue, Source: _____

## REFERRING DIAGNOSES *(CHECK ALL THAT APPLY)*

### Oncology

**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
□ 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
□ Thrombocythemia

### Prenatal/Postnatal

**ICD-10: _____**

□ Advanced Maternal Age
□ Autism Spectrum Disorder
□ Congenital Heart Defect
□ Cystic Hygroma
□ Developmental Delay
□ Multiple Congenital Anomalies
□ Increased Risk of Trisomy 18
□ Increased Risk of Trisomy 21
□ Fetal Demise
□ Missed Abortion
□ Spontaneous Abortion
□ Recurrent Pregnancy Loss
□ Trisomy: _____
□ Other: _____

## REQUESTED TESTING

### PCR:

□ **BCR-ABL1 p210 t(9;22) (Quantitative)**
□ **BCR-ABL1 p190 t(9;22) (Quantitative)**
□ **FLT3 Mutation Detection**
□ **IGVH Hypermutation Analysis**
□ **JAK2 V617F**
□ **Thrombophilia Panel** (Factor II, Factor V, MTHFR)
□ **B-Cell Clonality Assessment**
□ **T-cell Gamma Clonality Assessment**
□ **T-cell Beta Clonality Assessment**

### NEXT-GENERATION SEQUENCING:

* FLT3: If FLT3 is requested, please mark above in the PCR requested testing section.

□ **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)

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

□ **MPN Molecular Profile** (ABL1, ASXL1, CALR, CBL, CSF3R, EZH2, IDH1, IDH2, JAK2, MPL, SETBP1, SF3B1, SRSF2, TET2, TP53, U2AF1)

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

### MICROARRAY:

□ **CANCER MICROARRAY** Preferred test for detecting DNA copy number changes and loss of heterozygosity (LOH) in leukemias/lymphomas at time of diagnosis.
□ **PRENATAL MICROARRAY**
□ **POST NATAL MICROARRAY**

## PATIENT PREPARATION

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

## SPECIMEN COLLECTION

| Specimen Type | Volume | Container | Storage Conditions | Special Instructions |
|---|---|---|---|---|
| Amniotic Fluid | 10 mL of whole fluid | Sterile Centrifuge Tube | Room Temperature: 20-22°C | Do Not Freeze |
| Bone Marrow | Adult: 2-5 mL<br>Child ≥8 days: 2-5 mL<br>Newborn: 1-2 mL | EDTA Tube | Room Temperature: 20-22°C or<br>Refrigerated Temperature: 2-8°C | Do Not Freeze<br>Invert Tube 4-8 Times to Prevent Clots |
| Chorionic Villi | >10 mg of Villi | Sterile Centrifuge Tube with Transport Media | Room Temperature: 20-22°C | Do Not Freeze |
| Extracted DNA | 2 µg DNA | DNA RNase-free Microcentrifuge Tube | Refrigerated Temperature: 2-8°C | |
| Fixed Pellets | Pellet must be visible | Sterile Centrifuge Tube With 3:1, Methanol: Acetic Acid | Refrigerated Temperature: 2-8°C | Pellet should not be older than 1 week |
| Peripheral Blood | Adult: 2-5 mL<br>Child ≥8 days: 2-5 mL<br>Newborn: 1-2 mL | EDTA Tube | Room Temperature: 20-22°C or<br>Refrigerated Temperature: 2-8°C | Do Not Freeze<br>Invert Tube 4-8 Times to Prevent Clots |
| Products of Conception | >10 mg of Villi, Placenta, Placental Membrane, or Fetal Tissue | Sterile Specimen Cup or Centrifuge Tube with Sterile Saline or Transport Media (RPMI) | Room Temperature: 20-22°C or<br>Refrigerated Temperature: 2-8°C | Do Not Freeze<br>Do Not add Formalin |

**Special Instruction: Specimens for RNA based tests (PCR BCR/ABL1 p210 and p190) must be received in the lab within 72 hours of collection.**

**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), with the exception of samples collected in the State of New York, 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.

**Specimens Collected in the State of New York**

☐ I m a New York state resident, and by checking this box, I give permission for GAI to retain any remaining sample longer than 60 days after the completion of testing, and to be used as a de-identified sample for test development and improvement, internal validation, quality assurance, and training purposes.

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