Genetics Associates, LLC
A Division of Sonic Healthcare USA

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MOLECULAR/MICROARRAY REQUISITION FORM

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. Physician/Authorized Signature: _____	Address: 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:

□ **Myeloid Comprehensive Molecular Profile (56-gene)** (ABL1, ANKRD26, ASXL1, ATM, BCOR, BCORL1, BIRC3, BRAF, CALR, CARD11, CBL, CDKN2A, CEBPA, CSF3R, CXCR4, DDX41, DNMT3A, ELANE, ETV6, EZH2, FBXW7, FLT3, GATA2, IDH1, IDH2, IKZF1, JAK2, KIT, KRAS, MAP2K1, MPL, MYD88, NF1, NOTCH1, NPM1, NRAS, PHF6, PIGA, PPM1D, PRPF8, PTEN, PTPN11, RUNX1, SAMD9L, SETBP1, SF3B1, SH2B3, SRSF2, STAG2, STAT3, TET2, TP53, U2AF1, UBA1, WT1, ZRSR2)

□ **Myeloid Molecular Profile (24-gene)** (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 SNP MICROARRAY** Preferred test for detecting DNA copy number changes and loss of heterozygosity (LOH) in leukemias/lymphomas at time of diagnosis.
□ **PRENATAL SNP MICROARRAY**
□ **POST NATAL SNP 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	10-20 mL of whole fluid	Sterile centrifuge tube	Room temperature: 20-22°C Refrigerated: 2-8°C, if overnight	Do not freeze
Bone Marrow	Adult: 2-5 mL Child ≥8 days: 2-5 mL Newborn: 1-2 mL	EDTA tube preferred; NaHep accepted	Room temperature: 20-22°C	Do not freeze 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: 2-8°C	
Fixed Pellets	Pellet must be visible	Sterile centrifuge tube with 3:1, Methanol:Acetic Acid	Refrigerated: 2-8°C	Pellet should not be older than 1 week
Leukemic Blood	Adult: 2-5 mL Child ≥8 days: 2-5 mL Newborn: 1-2 mL	EDTA tube preferred; NaHep accepted	Room temperature: 20-22°C	Do not freeze Invert tube 4-8 times to prevent clots
Peripheral Blood	Adult: 2-5 mL Child ≥8 days: 2-5 mL Newborn: 1-2 mL	EDTA tube preferred; NaHep accepted	Room temperature: 20-22°C	Do not freeze Invert tube 4-8 times to prevent clots
Products of Conception	15-20 mg of villi, placenta, placental membrane, or fetal tissue	Sterile container with sterile saline, transport media, or RPMI	Refrigerated: 2-8°C	Do not freeze 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. Specimens received 10 days or greater past collection will be rejected.

Isolated or Extracted Nucleic Acid Acceptance Policy: Genetics Associates, LLC 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, LLC 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, LLC 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, LLC 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, LLC 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)** _____