

Oncology Requestion

ACCOUNT INFORMATION

Account name: _____
 Address: _____ City: _____ State: _____
 Zip code: _____ Ph: _____ Fax: _____

BILL TO: Facility / Client
 Patient / 3rd party – Billing information must be provided

Patient Name: (Last, First, Middle) _____
 Mother's Name: (if infant) _____
 Date of Birth: _____ Sex: _____ Patient ID / MR#: _____
 Hospital Inpatient Y / N _____ Collection Date: _____ Collection Time: _____ AM
 PM
 Ordering Physician (Full Name): _____ NPI: _____
PRINT NAME
 Physician Signature: _____
REQUIRED FOR MEDICARE/MEDICAID PATIENTS
 Phone: _____ Pager: _____ FAX: _____

Clinical Indication for Tests Ordered: _____

SPECIMEN INFORMATION

Bone Marrow Peripheral Blood
 Bone Marrow Aspirate Smears Peripheral Blood Smears
 Bone Marrow Touch Prep
 Bone Marrow Core Biopsy (formalin) Left Right
 Tissue: site/type _____
 Formalin Fixed Paraffin Embedded Tissue (FFPE)
 Block Urine CSF Body Fluid: _____

CLINICAL INFORMATION

Infection: HIV Hepatitis Other _____
History: Lymphadenopathy Mediastinal Mass Splenomegaly
Therapy: Chemotherapy Growth Factor Other _____
 Immunotherapy: _____
Status: Initial Relapse Remission Post Transplant
TENTATIVE DIAGNOSIS: _____

TESTS REQUESTED

Morphology
 Bone Marrow Morphology exam Peripheral Blood exam

Flow Cytometry (ACD-B preferred) Attach Current CBC Report
 Leukemia/Lymphoma Immunophenotyping
 PNH (Paroxysmal Nocturnal Hemoglobinuria)
 ALPS (Autoimmune Lymphoproliferative Syndrome)
 Process and hold - call next day with instructions
 Other Markers: _____

Molecular Diagnostics (EDTA preferred)
 B-cell Clonality PCR
 T-cell Clonality PCR
 BCL1/IGH: t(11;14) PCR
 BCL2/IGH: t(14;18) PCR (mbr, mcr)
 BCR/ABL: t(9;22) quantitative (p210 only) [CML]
 WBC Count: _____
 BCR/ABL: t(9;22) qualitative (p210, p190) [CML, ALL]
 JAK2 V617F mutation analysis PCR
 BRAF mutation analysis
 KRAS mutation analysis
 EGFR mutation analysis
 Loss of Heterozygosity (LOH): 1p/19q fragment analysis
 Other: _____

2110 Research Row, Suite 221
 Dallas, Texas 75235
 PHONE: 214-645-7057
 Toll Free: 877-887-8136
 FAX: 214-645-7035
 CLIA #45D-0659587, CAP #2723201



VERIPATH LABORATORIES

www.veripathlabs.com

PATIENT/3RD PARTY BILLING INFORMATION

ICD-9 Code(s) _____

Medicare patients with non-covered diagnoses must sign Advanced Beneficiary Notice (ABN) available at www.veripathlabs.com or by calling customer service at 214-645-7057 or toll free 877-887-8136 Signed ABN included

ICD-9 Codes applicable to each and every test requested should come only from the ordering physician, represent the reason for the test order at the time of order, and be supported by the patient's medical record. Physicians should order only tests that are medically necessary for the diagnosis or treatment of the patient. Tests ordered should be single laboratory tests appropriate for the patient's medical condition. Tests for screening purposes may be ordered, but may not be reimbursed.

Insured/Responsible Party Name: (if different from patient-Last, First, Middle) _____ Date of Birth: _____

Patient's relationship: Self Spouse
 Dependent Other
 Gender: Male Female
 Responsible Party Address: _____ City: _____
 State: _____ Zip: _____ Phone: _____

Employer's Name: _____ Employer's Phone: _____

Insurance Co. Name: _____ Insurance Co. Phone: _____

Insurance Co. Address: _____

Policy #: _____ Group #: _____

Medicare HMO Other
 Medicaid PPO
 Member ID#: _____

Referral Authorization/Precertification #: _____ Date/Time: _____
 Name: _____

TESTS REQUESTED (cont.)

Cytogenetics (NaHep preferred)
 Chromosomal Analysis FISH specify _____

FISH
 ALK: 2p23 IGH/BCL2: t(14;18)
 BIRC3/MALT1: t(11;18) MLL: 11q23
 BCR/ABL1: t(9;22) MYC/IGH: t(8;14)
 CBFβ: inv(16) MYCN: 2q23-24
 CCND1/IGH: t(11;14) MYC: 8q24
 Deletion/monosomy 5 PML/RARA: t(15;17)
 Deletion/monosomy 7 RB1: 13q14
 DDIT3: 12q13 RUNX1T1/RUNX1: t(8;21)
 EGFR: 7p12 SYT: 18q11.2
 ETV6/RUNX1: t(12;21) TP53: 17p13.1
 EWSR1: 22q12 UroVysion®
 FIP1L1/PDGFRα: 4q12 Other FISH (please call lab) _____
 FOXO1: 13q14
 HER2/neu _____

FISH Panels: CLL MM MDS ALL AML

Transplant Analysis
 FISH - X/Y sex chromosomes **Donor Sex:** Male Female
 STR Pre-transplant analysis STR Post-transplant analysis
 Donor Name: _____ Recipient Name: _____

Please provide dates of all previous transplants:

Other Tests
 Circulating Tumor Cell (CTC) Must be rec. w/in 24 hrs of collection, M-Th

VERIPATH USE ONLY Transport Container: _____ Total # of specimens: _____
 _____ Yellow _____ Green _____ Purple _____ Syringe _____ Conical _____ Red _____ Blue _____ Cup
 _____ Trans Tube _____ Block _____ Slides _____ Formalin _____ Other: _____
 Transport Conditions: Frozen Slushy Refrig Room Temp
 Destination: Other _____ Coag Cytogen Hemepath
 Flow Hist Mol Dx
 Initials: _____