

**ONCOLOGY REQUISITION**

Client Name/Account Number:

Client Address:

City/State/Zip:

Client Phone:

Client FAX:

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

**REQUIRED ORDER INFORMATION****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:

NPI:

Phone:

Pager:

FAX:

Clinical Indication  
for Tests Ordered:**SPECIMEN INFORMATION****Infection:**  HIV  Hepatitis  Other: \_\_\_\_\_**History:**  Lymphadenopathy  Mediastinal Mass  Splenomegaly**Therapy:**  Chemotherapy  Growth Factor  Other: \_\_\_\_\_  
 Immunotherapy: \_\_\_\_\_**Status:**  Initial  Relapse  Remission  Post transplant**Sex of Donor:**  Male  Female**TENTATIVE DIAGNOSIS** ALL AML, FAB type \_\_\_\_\_ CLL CML, blast crisis CML, chronic Solid Tumor: \_\_\_\_\_ Other: \_\_\_\_\_**\*Additional History:** \_\_\_\_\_**TESTS REQUESTED****BONE MARROW: MORPHOLOGY EXAM**

Facility performing morphology: \_\_\_\_\_

 Peripheral Blood \_\_\_\_\_ # slides Bone Marrow Aspirate Smears \_\_\_\_\_ # slides  Left  Right Bone Marrow Touch Preps \_\_\_\_\_ # slides  Left  Right Bone Marrow Core Biopsy \_\_\_\_\_ # slides  Left  Right**FLOW CYTOMETRY: IMMUNOPHENOTYPING** **Attach current CBC report** Leukemia/Lymphoma Immunophenotyping Process and hold sample for Immunophenotypic analysis

(call next day with instructions)

 Other: \_\_\_\_\_**PATIENT/3RD PARTY BILLING INFORMATION****ICD-9 Code(s)****Medicare patients with non-covered diagnoses must sign  
Advanced Beneficiary Notice (ABN) on reverse side.** 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

Responsible Party Address: (street, city, State, zip)

Sex:

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 #:

Name:

Date/Time:

**SPECIMEN TYPE** Blood (submit only if marrow unobtainable)  Bone marrow \_\_\_ aspirate \_\_\_ biopsy Tumor: site/type: \_\_\_\_\_ Other: \_\_\_\_\_**MOLECULAR DIAGNOSTICS: PCR** B-Cell Clonality PCR, JH gene rearrangement BCL1/IGH: t(11;14) PCR BCR/ABL: t(9;22) mRNA PCR, quantitative (p210) BCR/ABL: t(9;22) mRNA PCR, qualitative (p210) (p190) IGH/BCL2: t(14;18) PCR (mbr), (mcr) Loss of Heterozygosity (LOH): 1p/19q fragment analysis T-Cell Clonality PCR, Gamma gene rearrangement STR Pre-Transplant Analysis

Donor name \_\_\_\_\_ Recipient name \_\_\_\_\_

 STR Post-Transplant Analysis**Please send  
representative  
H&E slide along  
with specimen.****CYTOGENETICS** Check one  Chromosomal Analysis  Chromosomal Analysis with FISH (Specify FISH)  FISH only (Specify)**FISH TESTS:** BCR/ABL: t(9;22) [CML/ALL/AML] ETO/AML1: t(8;21) [AML] CBFB: inv(16): [AML] PML/RARA: t(15;17) [AML] deleted 5: [MDS] deleted 7: [MDS] TEL/AML1: t(12;21) [ALL] Other FISH (please call lab): \_\_\_\_\_ MYC/IGH: t(8;14) [ALL] BCL1/IGH: t(11;14) [mantle cell lymphoma] API2/MALT1: t(11;18) [marginal zone lymphoma] IGH/BCL2: t(14;18) [follicular lymphoma] MLL: 11q23 RB1: 13q14 P53: 17p13.1 CHIC2: deleted 4q [hypereosinophilic syndrome]**Solid Tumors** EWSR1: [Ewing sarcoma] NMYC: [neuroblastoma] FKHR: 13q14 [alveolar rhabdomyosarcoma] SYT: 18q11.2 [synovial sarcoma] FUS: 16p11.2 [myxoid sarcoma]**Transplant (opposite sex donor)** X/Y sex chromosomes**FISH PANELS:**  CLL Panel  Multiple Myeloma Panel  MDS Panel**VERIPATH** Transport Container:

Total # of specimens: \_\_\_\_\_

USE \_\_\_\_\_ Yellow \_\_\_\_\_ Green \_\_\_\_\_ Purple \_\_\_\_\_ Syringe \_\_\_\_\_ Conical \_\_\_\_\_ Red \_\_\_\_\_ Blue \_\_\_\_\_ Cup

ONLY \_\_\_\_\_ Trans Tube \_\_\_\_\_ Block \_\_\_\_\_ Slides \_\_\_\_\_ Formalin \_\_\_\_\_ Other: \_\_\_\_\_

Transport Conditions:

 Frozen  Slushy Refrig  Room TempDestination:  Other \_\_\_\_\_ Aston  Coag  Cytogen Flow  Hist  Mol Dx  OncoDx

Initials:

(A) Notifier(s):

(B) Patient Name:

(C) Identification Number:

### ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

**NOTE:** If Medicare doesn't pay for (D) \_\_\_\_\_ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the (D) \_\_\_\_\_ below.

(D) _____	(E) Reason Medicare May Not Pay:	(F) Estimated Cost:

#### WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the (D) \_\_\_\_\_ listed above.

**Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

#### (G) OPTIONS: Check only one box. We cannot choose a box for you.

**OPTION 1.** I want the (D) \_\_\_\_\_ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

**OPTION 2.** I want the (D) \_\_\_\_\_ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

**OPTION 3.** I don't want the (D) \_\_\_\_\_ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

#### (H) Additional Information:

**This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

(I) Signature:

(J) Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.