Cancer Cytogenetics Requisition

ACCOUNT INFORMATION

Account name: _____

Address: _____ **City:** _____ **State:** _____

Zip code: _____ **Ph:** _____ **Fax:** _____

Cytogenetics Laboratory
2330 Inwood Road, Suite EB3.304
Dallas, Texas 75235
LAB PHONE: 214-648-0930
LAB FAX: 214-648-0940
CUSTOMER SERVICE: 214-633-5227
CLIA #: 45D-0861764
CAP #: 2664213

UT Southwestern Medical Center
CLINICAL LABORATORY SERVICES

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 (Full Name):	NPI:

Phone:	Pager:	FAX:

Clinical Indication for Tests Ordered:

SPECIMEN INFORMATION

☐ Blood (Submit only if marrow is unobtainable)

☐ Bone Marrow___aspirate___biopsy

☐ Tumor site/type_____

☐ Other_____

☐ Products of conception

Initial Diagnosis? ☐ No ☐ Yes

S/P Transplant? ☐ No ☐ Yes Donor Sex M / F

PATIENT/3RD PARTY BILLING INFORMATION

ICD-10 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-10 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:

DIAGNOSTIC INFORMATION

Diagnosis ☐ Confirmed ☐ Suspected

Hematologic disorders:

- ☐ ALL
- ☐ AML, FAB type_____
- ☐ CLL
- ☐ CML
- ☐ Cytopenia*
- ☐ Lymphoma*
- ☐ Multiple myeloma
- ☐ Myeloproliferative disorder*
- ☐ Myelodysplastic disorder*
- ☐ Other_____

Tumors:

- ☐ Ewing sarcoma/PNET
- ☐ Germ cell tumor
- ☐ Hepatoblastoma
- ☐ Lymphoma*
- ☐ Neuroblastoma
- ☐ Rhabdomyosarcoma
- ☐ Synovial sarcoma
- ☐ Wilms tumor
- ☐ Other_____

***Specify Type/Additional History:** _____

TEST REQUESTED

Check one → ☐ Chromosomal Analysis ☐ Chromosomal Analysis with FISH (Specify FISH below) ☐ FISH only (see below)

FISH Tests:

- ☐ ALK:2p23
- ☐ BIRC3/MALT1: t(11;18)
- ☐ BCL6:3q27
- ☐ BCR/ABL1: t(9;22)
- ☐ CBFB: inv(16)
- ☐ CCND1/IGH: t(11;14)
- ☐ C-MET: 7q31.2
- ☐ deletion/monosomy 5
- ☐ PDGFRB: 5q33.1
- ☐ deletion/mosomony 7
- ☐ DDIT3: 12q13
- ☐ EGFR: 7p12
- ☐ ETV6/RUNX1: t(12;21)
- ☐ EWSR1: 22q12
- ☐ FIP1L1/PDGFRA: 4q12
- ☐ FGFR3/IGH: t(4;14)
- ☐ FOXO1: 13q14
- ☐ MDM2: 12q15
- ☐ FUS: 16p11.2
- ☐ HER2/neu
- ☐ IGH/BCL2: t(14;18)
- ☐ FGFR1: 8p11.2
- ☐ IGH/MAF: t(14;16)
- ☐ IGH/MAFB: t(14;20)
- ☐ MLL (KMT2A): 11q23
- ☐ MYC/IGH t(8;14)
- ☐ MYCN: 2p23-24
- ☐ MYC: 8q24
- ☐ PML/RARA: t(15;17)
- ☐ RB1: 13q14
- ☐ RUNX1T1/RUNX1: t(8;21)
- ☐ SS18: 18q11.2
- ☐ TFE-3: Xp11.2
- ☐ TFE-B: 6p21
- ☐ TP53: 17p13.1
- ☐ UroVysion

FISH Panels: ☐ CLL ☐ Multiple Myeloma ☐ MDS ☐ ALL ☐ AML ☐ Lymphoma

Lung Adenocarcinoma Panel (On FFPE Tissue): ☐ ALK ☐ ROS1 ☐ RET ☐ C-MET ☐ HER2

Transplant (analysis)

☐ X/Y chromosomes
Donor Sex
☐ male ☐ female

Other FISH (please call lab): _____