CANCER TEST REQUISITION FORM

Cytogenetic Laboratories
Indiana University School of Medicine
635 Barnhill Dr. MS 350, Indianapolis, IN 46202
317/274-2243 (Office) 317/278-1616 (Fax)
317/274-1053 or 317/274-2246 (Lab)

Patient Laboratory Label

CAP#: 16789-30 CLIA#: 15D0647198

1) PHYSICIAN(S):

Referring Physician:_____
Address:_____
City: _____ State: ____ Zip: _____
Phone:_____ Fax:_____

Primary Physician:_____
Address:_____
City: _____ State: ____ Zip: _____
Phone:_____ Fax:_____

FOR LABORATORY USE ONLY:

Date Received: _____/_____/_____ Family #: _____
Time Received: _____:_____am/pm Proband: ☐
Received By _____ Not Proband: ☐

BM/DN: ☐ BM/RN: ☐ BM/DA: ☐ BM/RA: ☐ ST: ☐
FISH: ☐ x _____ Probes FISH ONLY: ☐
Handling Charge: ☐ x _____ Handling ONLY: ☐

Lab Comment(s): Vacs: _____ green _____ purple; Other _____

2) PATIENT INFORMATION:

Patient Name: _____
Last Name *First Name* *Middle Initial*
Address: _____
Street *City* *State* *Zip Code*
Hospital: _____ Medical Record #: _____
Date of Birth: _____/_____/_____ Sex: ☐ Male ☐ Female **If Post-Transplant, Donor Sex:** ☐ Male ☐ Female ☐ Autologous
Month Day Year
WBC ($X10^3$): _____ Blasts: _____

3) CLINICAL INFORMATION *(DO NOT FREEZE SPECIMENS – ALL SPECIMENS MUST BE LABELED):*

Collection Date: _____/_____/_____ Collection Time:_____:_____am/pm Collected By: _____
Month Day Year
Referring Diagnosis:_____
ICD-10 Code(s):

4) SPECIMEN INFORMATION / REQUESTED TESTING:

☐ Bone Marrow **(*ROOM TEMP*)**
☐ Bone Core **(*ROOM TEMP*)**
☐ Peripheral Blood for Leukemic Studies **(*ROOM TEMP*)**
☐ Tumor / Type: _____ Site: _____
☐ Biliary Stricture
☐ Urine (Bladder Cancer)

REQUESTED TESTING

☐ Standard Chromosome Analysis (Karyotype) *ONLY*
☐ Chromosome Analysis & Fluorescence In Situ *(Select Probe/Panel below)*
☐ Fluorescence In Situ (FISH) Analysis *ONLY*
☐ Fluorescence In Situ STAT analysis **(t(15;17) PML/RARA probe *ONLY*)**

If FISH requested above, please select probe(s)/panel(s) from below:

☐ 1q21	☐ 5q33.2 (PDGFRB)	☐ 9p21 (CDKN2A)	☐ 12p13 (ETV6)	☐ t(14;16) IGH/MAF	☐ del(20q)
☐ 2p24.1 (MYCN)	☐ -5/del(5q)	☐ t(9;22) BCR/ABL1	☐ t(12;21) ETV6/RUNX1	☐ t(15;17) PML/RARA	☐ 22q12 (EWSR1)
☐ inv(3) PSMD2/MECOM	☐ del(7q)	☐ 9q34 (ASS)	☐ 13q14 (FKHR)	☐ inv(16) MYH11/CBFB	☐ X/Y
☐ 4q12 (PDGFRA/CHIC2)	☐ 8 Centromere	☐ 11q23 (MLL)	☐ 13q14 (RB1 & D13S319)	☐ 17p13.1 (TP53)	
☐ t(4;14) FGFR3/IGH	☐ t(8;21) RUNX1T1/RUNX1	☐ 12 Centromere	☐ 14q32.3 (IGH)	☐ 17q21.1 (RARA)	

Panels:

☐ **ALL Panel**: 4/10/17cen, 9p21, t(9;22), 11q23 (MLL), t(12;21)
☐ **MDS Panel**: -5/del(5q), del(7q), 8cen, 11q23 (MLL), del(20q) **All included in AML Panel*
☐ **MPN Panel**: -5/del(5q), del(7q), 8cen, t(9;22), 9q34, del(20q)
☐ **AML Panel**: inv(3), -5/del(5q), del(7q), 8cen, t(8;21), 11q23 (MLL), t(15;17), inv(16), del(20q)
t(15;17) Stat? ☐ **Yes** ☐ **No**
☐ **Lymphoma Panel**: 8q24 (MYC), t(8;14), t(14;18)
☐ **Plasma Cell Myeloma Panel**: 1q21, 5p/5q, 7q, t(11;14), 13q14.2(RB1)/13q14.3 (D13S319), 14q32.3 (IGH), 17p13.1 (TP53)
☐ **CLL Panel**: 11q22.3 (ATM), 12cen, 13q14.3(D13S319), 13q34(LAMP1),17p13.1 (TP53)

Lymphoma Probes:

☐ 2p23.2 (ALK)	☐ t(8;14) MYC/IGH	☐ t(11;14) CCND1/IGH	☐ t(14;18) IGH/BCL2
☐ 3q27 (BCL6)	☐ 8q24 (MYC)	☐ t(11;18) BIRC3/MALT1	☐ 18q21 (MALT1)

Paraffin-Embedded Tissue Section (PET) Probes:
☐ HER2 (Breast Cancer, Gastric Cancer)

Other FISH Probes:
UroVysion (Chromosomes 3, 7, 17, 9p21):
☐ Hematuria; Bladder Cancer ☐ Biliary Stricture

CONTINUES ON BACK

5) SPECIMEN SHIPPING/HANDLING INFORMATION

Specimen	Collection	Container(s)	Instructions
Peripheral Blood for cancer analysis	7-10 mL whole blood (adults) 2-4 mL whole blood (infants)	Dark Green-top sodium heparin vacutainer tube.	**Keep at room temperature.**
Bone Marrow Aspirate	**0.5 mL minimum** 2 mL preferred for normal WBC ↓ WBC requires more ↑ WBC requires less 1-2 mL preferred	Dark Green-top sodium heparin vacutainer tube.	**Keep at room temperature.**
Formalin-fixed, Paraffin-Embedded Tissue (PET)	4-micron sections on positively charged, circled/marked slides (2-3 slides are sufficient) Corresponding H&E section with area of tumor marked. **NO DECALCIFIED BONE!**	Slides - **NO BLOCKS**	Copy of Pathology report and patient/hospital billing information MUST BE INCLUDED with slides.
Urine (Bladder Cancer) *For Urovysion Studies ONLY*	≥ 30 mL	50 mL centrifuge tubes or other tightly capped plastic container.	**Keep at room temperature.** Copy of Pathology report and patient/hospital billing information MUST BE INCLUDED.

6) SPECIMEN HANDLING REQUIREMENTS

- Use sterile technique; close all containers tightly.
- **Do not freeze any specimen type.**
- Label all containers and requisition forms with patient name, MRN, date of collection, and physician name.
- **Specimens should be received within 24 hours of collection.**

7) PATIENT BILLING INFORMATION:

☐ Bill Patient's Insurance: Policy #: _____ Group #: _____

Insurance/Managed Care plan: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Relationship to Insured: ☐ Self ☐ Spouse ☐Other: _____ Insured's Social Security #: _____

☐ ***OR*** Copy of patient's insurance card attached

☐ Bill Medicare: _____

☐ Bill Medicaid: _____

☐ Bill Patient/Self-Pay *(Please Attach Patient Demographic Sheet)*

☐ Bill Hospital: _____