

CANCER TEST REQUISITION FORM



Cytogenetic Laboratories

Indiana University School of Medicine
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317/274-2243 or 317/274-2246 (Lab)

Patient Laboratory Label

CAP#: 16789-30 CLIA#: 15D0647198

1) PHYSICIAN(S):	FOR LABORATORY USE ONLY:
Referring Physician: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____ _____ Primary Physician: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____	Date Received: ____/____/____ Family #: _____ Time Received: ____:____am/pm Proband: <input type="checkbox"/> Received By: _____ Not Proband: <input type="checkbox"/> BM/DN: <input type="checkbox"/> BM/RN: <input type="checkbox"/> BM/DA: <input type="checkbox"/> BM/RA: <input type="checkbox"/> ST: <input type="checkbox"/> FISH: <input type="checkbox"/> x _____ Probes FISH <u>ONLY</u> : _____ Handling Charge: <input type="checkbox"/> x _____ Handling <u>ONLY</u> : <input type="checkbox"/> 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

WBC (X10³): _____ Blasts: _____

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

Collection Date: _____ Collection Time: _____ Collected By: _____

Referring Diagnosis: _____ ICD-10 Code(s): _____

4) SPECIMEN INFORMATION and 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)

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

1q21	4q12 (PDGFRA/CHIC2)	del(6q) (PRDM1, MYB)	t(9;22) BCR/ABL1	13q14 (FOXO1)	17p13.1 (TP53)
t(1;19) (PBX1/TCF3)	t(4;14) FGFR3/IGH	del(7q)	9q34 (ASS1)	13q14 (RB1, D13S319)	17q21.1 (RARA)
1q25.2 (ABL2)	5q32 (PDGFRB)	8 Centromere	11q23 (KMT2A)	14q32.3 (IGH)	del(20q)
2p24.1 (MYCN)	-5/del(5q)	t(8;21) RUNX1T1/RUNX1	12 Centromere	t(14;16) IGH/MAF	22q12 (EWSR1)
inv(3) RPN1/MECOM	t(6;9) (DEK/NUP214)	9p21 (CDKN2A)	12p13 (ETV6)	t(15;17) PML/RARA	X/Y
	NUP98	9q34.1 (ABL1)	t(12;21) ETV6/RUNX1	inv(16) CBFβ/MYH11	Xp22.3/Yp11.2 (CRLF2)

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)

Panels:

ALL Panel – Pediatric (<18): CRLF2, t(1;19), ABL2, 4/10/17cen, PDGFRB, 9p21, ABL1, t(9;22), KMT2A, t(12;21)	MPN Panel: -5/del(5q), del(7q), 8cen, t(9;22), 9q34, del(20q)	Lymphoma Panel: 8q24(MYC), t(8;14), t(14;18)
ALL Panel – Adult (>18): CRLF2, t(1;19), 4/10/17cen, 9p21, t(9;22), KMT2A, t(12;21) *Ph-like ALL Reflex for t(9;22) neg	AML Panel: inv(3), -5/del(5q), t(6;9), del(7q), 8cen, t(8;21), NUP98, 11q23(KMT2A), t(15;17), inv(16), del(20q)	Plasma Cell Myeloma Panel: 1q21, 5p/5q, 7q, t(11;14), 13q14.2(RB1)/13q14.3 (D13S319), 14q32.3 (IGH), 17p13.1 (TP53)
Ph-like ALL Reflex (Adult): ABL2, PDGFRB, ABL1	t(15;17) Stat? Yes No	CLL Panel: del(6q), 11q22.3(ATM), 12cen, 13q14.3(D13S319), 13q34(LAMP1), 17p13.1(TP53)
MDS Panel: -5/del(5q), del(7q), 8cen, 11q23 (KMT2A), del(20q) *All in AML Panel		

Lymphoma Probes:

3q27 (BCL6)	t(8;14) MYC/IGH	t(11;14) CCND1/IGH	t(14;18) IGH/BCL2
	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	7-10mL whole blood (adults) 2-4mL whole blood (infants)	Dark Green-top sodium heparin 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 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 <u>MUST BE INCLUDED</u> with slides.
Urine (Bladder Cancer) *For UroVysion Studies <u>ONLY</u> *	≥ 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 <u>MUST BE INCLUDED</u> .

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: _____