

CANCER TEST REQUISITION FORM



Cytogenetic Laboratories
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Patient Laboratory Label

CAP#: 16789-30 CLIA#: 15D0647198

1) PHYSICIAN(S):	FOR LABORATORY USE ONLY:
Referring Physician: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____ <hr/> Primary Physician: _____ 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 ONLY: <input type="checkbox"/> Handling Charge: <input type="checkbox"/> x _____ Handling ONLY: <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: <input type="checkbox"/> Male <input type="checkbox"/> Female If Post-Transplant, Donor Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Autologous			
WBC (X10 ³): _____		Blasts: _____	

3) CLINICAL INFORMATION (DO NOT FREEZE SPECIMENS – ALL SPECIMENS MUST BE LABELED):		
Collection Date: ____/____/____ Collection Time: ____ am/pm Collected By: _____		
Referring Diagnosis: _____		

4) SPECIMEN INFORMATION and REQUESTED TESTING:	
<input type="checkbox"/> Bone Marrow (ROOM TEMP) <input type="checkbox"/> Bone Core (ROOM TEMP) <input type="checkbox"/> Peripheral Blood for Leukemic Studies (ROOM TEMP) <input type="checkbox"/> Tumor / Type: _____ Site: _____ <input type="checkbox"/> Biliary Stricture <input type="checkbox"/> Urine (Bladder Cancer)	REQUESTED TESTING <input type="checkbox"/> Standard Chromosome Analysis (Karyotype) <u>ONLY</u> <input type="checkbox"/> Chromosome Analysis & Fluorescence In Situ (Select Probe/Panel below) <input type="checkbox"/> Fluorescence In Situ (FISH) Analysis <u>ONLY</u> <input type="checkbox"/> Fluorescence In Situ STAT analysis (t(15;17) PML/RARA probe <u>ONLY</u>)
FISH Panels – Cancer/Oncology: <input type="checkbox"/> FISH ALL Panel – Pediatric (≤18): CRLF2, t(1;19), ABL2, 4/10/17cen, PDGFRB, 9p21, ABL1, t(9;22), KMT2A, t(12;21) <input type="checkbox"/> FISH ALL Panel – Adult (>18) with Ph-like Reflex: CRLF2, t(1;19), 4/10/17cen, 9p21, t(9;22), KMT2A, t(12;21); reflex for t(9;22) neg includes ABL2, PDGFRB, ABL1 <input type="checkbox"/> FISH CLL Panel del(6q), t(11;14), ATM, 12cen, 13q, TP53 <input type="checkbox"/> FISH MDS Panel: -5/del(5q), del(7q), 8cen, 11q23 (KMT2A), del(20q) *All in AML Panel	<input type="checkbox"/> FISH MPN Panel: -5/del(5q), del(7q), 8cen, t(9;22), 9q34, del(20q) <input type="checkbox"/> FISH AML Panel: inv(3), -5/del(5q), t(6;9), del(7q), 8cen, t(8;21), KMT2A, t(15;17), t(16;16), del(20q) t(15;17) Stat? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> FISH Lymphoma Panel: BCL6, MYC, t(14;18), reflex t(8;14) if MYC abnormal
FISH PET – Cancer/Oncology: <input type="checkbox"/> FISH-HER2 Breast Cancer <input type="checkbox"/> FISH-HER2 Gastroesophageal Cancer <input type="checkbox"/> FISH-HER2 Non-Breast Tissue	<input type="checkbox"/> FISH Plasma Cell Myeloma Panel with Reflex: 1q21, 5p, 5q, 7q, t(11;14), 13q14.2 (RB1)/13q14.3 (D13S319), IGH, 17p13.1 (TP53); reflex if IGH rearranged to t(4;14) FGFR3::IGH and t(14;16) IGH::MAF UROVYSION <input type="checkbox"/> FISH UroVysion Panel (Biliary brushing) <input type="checkbox"/> FISH UroVysion Panel (Urine)
FISH Individual Probes – Cancer/Oncology <input type="checkbox"/> 1q21.8p <input type="checkbox"/> 4q12 (PDGFRA,CHIC2) <input type="checkbox"/> 8 Centromere,del(20q) <input type="checkbox"/> 9q34 (ASS1) <input type="checkbox"/> t(12;21) ETV6::RUNX1 <input type="checkbox"/> t(16;16) CBFβ::MYH11 <input type="checkbox"/> t(1;19) PBX1::TCF3 <input type="checkbox"/> t(4;14) FGFR3::IGH <input type="checkbox"/> 8q24 (MYC) <input type="checkbox"/> t(11;14) CCND1::IGH <input type="checkbox"/> 13q14 (FOXO1) <input type="checkbox"/> 17p13.1 (TP53) <input type="checkbox"/> 1q25.2 (ABL2) <input type="checkbox"/> 5q33.2 (PDGFRB) <input type="checkbox"/> t(8;14) MYC::IGH <input type="checkbox"/> t(11;18) BIRC3::MALT1 <input type="checkbox"/> 13q14 (RB1,D13S319) <input type="checkbox"/> 17q21.1 (RARA) <input type="checkbox"/> 2p23.2 (ALK) <input type="checkbox"/> -5/del(5q) <input type="checkbox"/> t(8;21) RUNX1T1::RUNX1 <input type="checkbox"/> 11p15.4 (NUP98) <input type="checkbox"/> 14q32.3 (IGH) <input type="checkbox"/> del(20q),8 Centromere <input type="checkbox"/> 2p24.1 (MYCN) <input type="checkbox"/> t(6;9) DEK::NUP214 <input type="checkbox"/> 9p21 (CDKN2A) <input type="checkbox"/> 11q23 (KMT2A) <input type="checkbox"/> t(14;16) IGH::MAF <input type="checkbox"/> 22q12 (EWSR1) <input type="checkbox"/> 3q27 (BCL6) <input type="checkbox"/> del(6q) <input type="checkbox"/> 9q34.1 (ABL1) <input type="checkbox"/> 12 Centromere <input type="checkbox"/> t(14;18) IGH::BCL2 <input type="checkbox"/> X/Y <input type="checkbox"/> inv(3) RPN1::MECOM <input type="checkbox"/> del(7q) <input type="checkbox"/> t(9;22) BCR::ABL1 <input type="checkbox"/> 12p13 (ETV6) <input type="checkbox"/> t(15;17) PML::RARA <input type="checkbox"/> Xp22.3/Yp11.2 (CRLF2)	Individual PET probes (each probe reported separately) <input type="checkbox"/> FISH-3q27 (BCL6) <input type="checkbox"/> FISH t(8;14) MYC:IGH <input type="checkbox"/> FISH 8q24 (MYC) <input type="checkbox"/> FISH-t(14;18) IGH::BCL2

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 preferred)	50 mL centrifuge tubes or other tightly capped plastic container.	Keep at room temperature. Include copy of pathology report.
Biliary Brushing *For UroVysion Studies <u>ONLY</u> *	Specimen from endoscopic retrograde cholangiopancreatography (ERCP) brushing	ThinPrep PreservCyt® Solution from Hologic (containers provided by the Cytogenetics Laboratory)	Keep at room temperature. Ship to laboratory within 24 hours. Refrigerate if there is a delay in shipping. Include copy of pathology report.

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: _____