

# 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: _____	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: _____
Primary Physician: _____ Phone: _____ Fax: _____	

2) PATIENT INFORMATION:
Patient Name: _____ <i>Last Name First Name Middle Initial</i>
Address: _____ <i>Street City State Zip Code</i>
Hospital: _____ Medical Record #: _____
Date of Birth: ____/____/____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <b>If Post-Transplant, Donor Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Autologous
WBC (X10 <sup>3</sup> ): _____ Blasts: _____

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

4) SPECIMEN INFORMATION and REQUESTED TESTING:	
<input type="checkbox"/> Bone Marrow ( <b>ROOM TEMP</b> ) <input type="checkbox"/> Bone Core ( <b>ROOM TEMP</b> ) <input type="checkbox"/> Peripheral Blood for Leukemic Studies ( <b>ROOM TEMP</b> ) <input type="checkbox"/> Tumor / Type: _____ Site: _____ <input type="checkbox"/> Biliary Stricture <input type="checkbox"/> Urine (Bladder Cancer)	<b>REQUESTED TESTING</b> <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> )
<b>FISH Panels – Cancer/Oncology:</b> <input type="checkbox"/> <b>FISH ALL Panel – Pediatric (≤18):</b> CRLF2, t(1;19), ABL2, 4/10/17cen, PDGFRB, 9p21, ABL1, t(9;22), KMT2A, t(12;21) <input type="checkbox"/> <b>FISH ALL Panel – Adult (&gt;18) with Ph-like Reflex:</b> 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"/> <b>FISH CLL Panel</b> del(6q), ATM, 12cen, 13q, TP53 <input type="checkbox"/> <b>FISH MDS Panel:</b> -5/del(5q), del(7q), 8cen, 11q23 (KMT2A), del(20q) *All in AML Panel	<input type="checkbox"/> <b>FISH MPN Panel:</b> -5/del(5q), del(7q), 8cen, t(9;22), 9q34, del(20q) <input type="checkbox"/> <b>FISH AML Panel:</b> inv(3), -5/del(5q), t(6;9), del(7q), 8cen, t(8;21), KMT2A, t(15;17), t(16;16), del(20q) <b>t(15;17) Stat?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>FISH Lymphoma Panel:</b> BCL6, MYC, t(14;18), reflex t(8;14) if MYC abnormal
<b>FISH PET – Cancer/Oncology:</b> <input type="checkbox"/> FISH-HER2 Breast Cancer <input type="checkbox"/> FISH-HER2 Gastroesophageal Cancer <input type="checkbox"/> FISH-HER2 Non-Breast Tissue	<b>UROVYSION</b> <input type="checkbox"/> <b>FISH UroVysion Panel</b> (Biliary brushing) <input type="checkbox"/> <b>FISH UroVysion Panel</b> (Urine)

<b>FISH Individual Probes – Cancer/Oncology</b> <input type="checkbox"/> 1q21/8p <input type="checkbox"/> t(1;19) (PBX1/TCF3) <input type="checkbox"/> 1q25.2 (ABL2) <input type="checkbox"/> 2p23.2 (ALK) <input type="checkbox"/> 2p24.1 (MYCN) <input type="checkbox"/> 3q27 (BCL6) <input type="checkbox"/> inv(3) RPN1/MECOM <input type="checkbox"/> 4q12 (PDGFRA/CHIC2) <input type="checkbox"/> t(4;14) FGFR3/IGH <input type="checkbox"/> 5q33.2 (PDGFRB) <input type="checkbox"/> -5/del(5q) <input type="checkbox"/> t(6;9) (DEK/NUP214) <input type="checkbox"/> del(6q) (PRDM1, MYB) <input type="checkbox"/> del(7q) <input type="checkbox"/> 8 Centromere/del 20q <input type="checkbox"/> 8q24 (MYC) <input type="checkbox"/> t(8;14) MYC/IGH <input type="checkbox"/> t(8;21) RUNX1T1/RUNX1 <input type="checkbox"/> 9p21 (CDKN2A) <input type="checkbox"/> 9q34.1 (ABL1) <input type="checkbox"/> t(9;22) BCR/ABL1 <input type="checkbox"/> 9q34 (ASS1) <input type="checkbox"/> t(11;14) CCND1/IGH <input type="checkbox"/> t(11;18) BIRC3/MALT1 <input type="checkbox"/> 11p15.4 (NUP98) <input type="checkbox"/> 11q23 (KMT2A) <input type="checkbox"/> 12 Centromere <input type="checkbox"/> 12p13 (ETV6) <input type="checkbox"/> t(12;21) ETV6/RUNX1 <input type="checkbox"/> 13q14 (FOXO1) <input type="checkbox"/> 13q14 (RB1, D13S319) <input type="checkbox"/> 14q32.3 (IGH) <input type="checkbox"/> t(14;16) IGH/MAF <input type="checkbox"/> t(14;18) IGH/BCL2 <input type="checkbox"/> t(15;17) PML/RARA <input type="checkbox"/> t(16;16) CFBF/MYH11 <input type="checkbox"/> 17p13.1 (TP53) <input type="checkbox"/> 17q21.1 (RARA) <input type="checkbox"/> del(20q)/8 Centromere <input type="checkbox"/> 22q12 (EWSR1) <input type="checkbox"/> X/Y <input type="checkbox"/> Xp22.3/Yp11.2 (CRLF2)
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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.	<b>Keep at room temperature.</b>
Bone Marrow Aspirate	<b>0.5 mL minimum</b> 2 mL preferred for normal WBC ↓ WBC requires more ↑ WBC requires less 1-2 mL preferred	Dark Green-top sodium heparin tube.	<b>Keep at room temperature.</b>
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. <b>NO DECALCIFIED BONE!</b>	Slides - <b>NO BLOCKS</b>	Copy of Pathology report and patient/hospital billing information <b><u>MUST BE INCLUDED</u></b> 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.	<b>Keep at room temperature.</b>  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)	<b>Keep at room temperature.</b> 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: \_\_\_\_\_