

CENTER FOR HUMAN GENETICS LABORATORY

University Hospitals Laboratory Services Foundation

W.O. Walker Center, 6th Floor

10524 Euclid Avenue

Cleveland, OH 44106 Tel: (216) 983-1134 Fax: (216) 983-1144

Cytogenetics and Molecular Genetics Requisition (for Cancer Specimens)

Medical Record Number: _____

SPECIMEN INFORMATION

Type: Peripheral Blood Bone Marrow Lymph node Solid Tumor (specify) _____ Other (specify) _____

★ **Date of specimen collection:** _____ ★ **Where drawn (institution):** _____

Post-treatment Y / N Date of last treatment _____ Medication/treatment used _____

PATIENT INFORMATION

Name (Last, First) _____ Phone (H) (____) _____ DOB ____/____/____

Address _____ (W) (____) _____ SS# ____-____-____

City/State/Zip _____ Sex: Male Female

★ **Transplant patient Y/N** Donor Recipient ★ **Sex of transplant match:** Male Female

REFERRING PHYSICIAN

Name _____ Results also sent to _____

Phone: _____ Fax: _____

BILLING INFORMATION

Bill: Insurance Referring Institution Patient Other Party

Ins.Co./Instit. _____ Name _____

Please attach appropriate billing information if available

INDICATIONS FOR TESTING (ICD9 Codes are in parentheses)

- | | |
|---|---|
| <input type="checkbox"/> Acute lymphocytic leukemia (ALL) (204.00) | <input type="checkbox"/> Lymphoproliferative disorder (238.79) |
| <input type="checkbox"/> Acute myelocytic leukemia (AML)(205.00) | <input type="checkbox"/> Monoclonal Gammopathy (273.1) |
| <input type="checkbox"/> Acute promyelocytic leukemia (APL) (205.00) | <input type="checkbox"/> Plasma Cell Dyscrasia (273.9) |
| <input type="checkbox"/> Anemia (suspected leukemia) (285.9, 208.80) | <input type="checkbox"/> Multiple Myeloma (203.00) |
| <input type="checkbox"/> Burkitt's Lymphoma (200.20) | <input type="checkbox"/> Myelodysplastic Syndrome (288.75) |
| <input type="checkbox"/> Chronic myelogenous leukemia (CML) (205.10) | <input type="checkbox"/> Myelofibrosis (suspected leukemia) (289.83, 208.80) |
| <input type="checkbox"/> Chronic lymphocytic leukemia (CLL) (204.10) | <input type="checkbox"/> Myeloma (203.0) |
| <input type="checkbox"/> Hodgkin's Lymphoma (201.9) | <input type="checkbox"/> Myeloproliferative Syndrome (238.79) |
| <input type="checkbox"/> Non-Hodgkin's Lymphoma (202.80) | <input type="checkbox"/> Neutropenia (suspected leukemia) (288.0, 208.80) |
| <input type="checkbox"/> Lymphoma (202.80) | <input type="checkbox"/> Pancytopenia (suspected leukemia) (284.0, 208.80) |
| <input type="checkbox"/> Leukemia (known or suspected) (208.80) | <input type="checkbox"/> Polycythemia vera (suspected leukemia) (238.4, 208.80) |
| <input type="checkbox"/> Leukopenia (suspected leukemia) (288.0, 208.80) | <input type="checkbox"/> Thrombocytopenia (suspected leukemia) (287.5, 208.80) |
| <input type="checkbox"/> Leukocytosis (suspected leukemia) (288.8, 208.80) | <input type="checkbox"/> Thrombocytosis (suspected leukemia) (289.9, 208.80) |
| <input type="checkbox"/> Lymphocytosis (suspected leukemia) (288.8, 208.80) | <input type="checkbox"/> Other _____ |

TEST REQUESTED

Cytogenetics: (Requires heparinized sample or Green Top tube)

Chromosome Analysis

FISH: (Requires heparinized sample or Green Top tube)

★ FISH for previous abnormality ★

- | | | |
|--|---|--|
| <input type="checkbox"/> t(8;21) (AML, ETO/AML1) | <input type="checkbox"/> Myeloma Panel (including the following) | <input type="checkbox"/> MDS Panel (including the following) |
| <input type="checkbox"/> t(9;22) (CML and ALL, BCR/ABL) | <input type="checkbox"/> t(4;14) (FGFR3/IGH) | <input type="checkbox"/> -5/5q- <input type="checkbox"/> 13q- |
| <input type="checkbox"/> t(15;17) (APL, PML/RAR α) | <input type="checkbox"/> -13/13q- (D13S319, LAMP1) | <input type="checkbox"/> -7/7q- <input type="checkbox"/> 20q- |
| <input type="checkbox"/> Inv 16/t(16;16)/del16 (AML-M ₄ , CBFB) | <input type="checkbox"/> 17p- (p53) | <input type="checkbox"/> +8 |
| <input type="checkbox"/> 9p-, +9 (p16 probe) | <input type="checkbox"/> Lymphoma Panel (including the following) | <input type="checkbox"/> CLL Panel (6q-,11q-,13/13q-,17p-,+12) |
| <input type="checkbox"/> Pediatric Pre-B ALL Panel (COG) | <input type="checkbox"/> t(14;18) (BCL2/IGH) | <input type="checkbox"/> CHIC2 deletion (FIP1L1-PDGFR α) |
| <input type="checkbox"/> MLL involvement (11q23) | <input type="checkbox"/> t(11;14) (CCND1/IGH) | |
| <input type="checkbox"/> t(12;21) (Pediatric ALL, TEL/AML1) | <input type="checkbox"/> t(8;14) (c-MYC/IGH) | <input type="checkbox"/> Other _____ |

Molecular: (Requires Purple Top tube--EDTA)

- | | | |
|---|---|--|
| <input type="checkbox"/> Factor V Leiden (ICD9=286.3) | <input type="checkbox"/> Factor V HR2 (done if Leiden positive) | <input type="checkbox"/> Quantitative PCR for PML/RARA |
| <input type="checkbox"/> Prothrombin (ICD9=286.3) | <input type="checkbox"/> Hereditary Hemochromatosis | <input type="checkbox"/> Quantitative PCR for BCR/ABL |
| <input type="checkbox"/> MTHFR (ICD9=286.3) | <input type="checkbox"/> NPM1 Mutation Analysis | <input type="checkbox"/> JAK2 Mutation Analysis |
| <input type="checkbox"/> T-Cell Gene Rearrangements | <input type="checkbox"/> DNA Extract and Store | <input type="checkbox"/> FLT3 Analysis |
| | | <input type="checkbox"/> Other _____ |

Pre-Transplant:

-- CHIMERISM STUDY --

Post-Transplant:

- | | |
|--|--|
| <input type="checkbox"/> Donor (Requires Purple Top tube--EDTA) | <input type="checkbox"/> FISH (X/Y Sex Chromosomes) (Requires Green Top tube--NaHep) |
| <input type="checkbox"/> Recipient Blood (Requires Purple Top tube--EDTA) | OR - |
| <input type="checkbox"/> Recipient Buccal Swab | <input type="checkbox"/> DNA (Microsatellite Analysis) (Requires Purple Top tube--EDTA) |