

Place Patient Label Here



Oncology Genetic Testing Requisition

Cytogenetic and Molecular Genetics Laboratory
 3333 Burnet Ave., TCHRF Room 1042,
 ML 7016, Cincinnati, Ohio 45229-3039
 For test inquiries or local courier service call:
Phone (513)636-4474 or FAX (513)636-4373
www.cincinnatichildrens.org/genetics
 patient presented for lab draw specimen only

Patient/Physician Information					
Specimen Date	Specimen Time	Request Date	Patient Name (Last, First)	Sex	Date of Birth
Hospital MR#	Referring Institution		Referring Physician	Phone	Fax
Email			Physician Address		
Lab Address			Physician's Signature (required)		

Please review carefully. Complete ALL 4 sections below AND attach patient billing information

1. Bill: Please see 2nd page of requisition

2. Specimen Information

Bone marrow Oncology blood Lymph node Solid Tumor (specify) _____
 Paraffin Embedded Tissue Other (Specify) _____
WBC _____ % **Blasts** _____ Pre-transplant Post transplant
 Disease status: New leukemia Remission Relapse (E)COG Study Known Down syndrome Primary solid tumor Metastatic tumor

3. Suspected Diagnosis / Indications (REQUIRED)

<input type="checkbox"/> Acute lymphocytic leukemia (ALL) <input type="checkbox"/> Acute myelocytic leukemia (AML) <input type="checkbox"/> Acute promyelocytic leukemia (APL) <input type="checkbox"/> Adenopathy <input type="checkbox"/> Anemia <input type="checkbox"/> Burkitt lymphoma <input type="checkbox"/> Chronic myelogenous leukemia (CML) <input type="checkbox"/> Chronic lymphocytic leukemia (CLL) <input type="checkbox"/> Ewing sarcoma <input type="checkbox"/> Hodgkin lymphoma	<input type="checkbox"/> Leukocytosis <input type="checkbox"/> Leukopenia <input type="checkbox"/> Leukemia <input type="checkbox"/> Lymphoma <input type="checkbox"/> Lymphocytosis <input type="checkbox"/> Lymphoproliferative disorder <input type="checkbox"/> Monoclonal gammopathy <input type="checkbox"/> Multiple myeloma <input type="checkbox"/> Myelodysplastic syndrome or disease (MDS) <input type="checkbox"/> Myeloma	<input type="checkbox"/> Myeloproliferative disease (MPS or MPD) <input type="checkbox"/> Neutropenia <input type="checkbox"/> Non-Hodgkin lymphoma (NHL) <input type="checkbox"/> Pancytopenia <input type="checkbox"/> Polycythemia vera (PV) <input type="checkbox"/> Sarcoma <input type="checkbox"/> Thrombocytopenia <input type="checkbox"/> Thrombocytosis <input type="checkbox"/> Wilms tumor <input type="checkbox"/> Other _____
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4. Test Requested

Molecular Genetic Analysis Test Request: (3 ml bone marrow or blood in an EDTA tube - purple top)

Molecular analysis for leukemia translocation
 o BCR/ABL - t(9;22) by RT-PCR (QUALITATIVE) o PML/RAR α - t(15;17) by RT-PCR
 NPM-1
 Tamoxifen GPS Testing (CYP2D6)
 Bone marrow engraftment by STR - Same sex donor and recipient (STR=BME)
 o Pre-transplant host sample o Post transplant sample o Donor sample

You MUST call 513-636-4685 or 513-636-8657 to schedule this test: Bone marrow engraftment (WBC sub-populations) STR FISH

Molecular Quantitative Genetic Analysis (5-10ml blood or 3-5ml bone marrow in EDTA test same day/overnight on ICE)

BCR/ABL - t(9;22) QUANTITATIVE (p210) : new diagnosis JAK2 QUANTITATIVE (v617F) : new diagnosis
 BCR/ABL - t(9;22) QUANTITATIVE (p210) : monitoring disease JAK2 QUANTITATIVE (v617F): recurrent disease

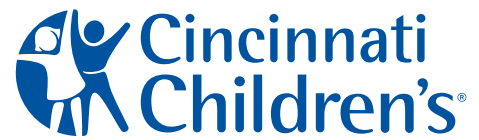
Cytogenetic Test	FISH (Fluorescence In Situ Hybridization) - Specify below - This is not a complete list of available FISH probes;
*3 ml bone marrow or blood in sodium heparin (green top) tube **3 ml bone marrow or blood in EDTA (purple top) tube If in media, type: _____ <input type="checkbox"/> Oncology Chromosome Analysis * <input type="checkbox"/> Oncology Microarray ** <input type="checkbox"/> Constitutional (blood) Chromosome Analysis* <input type="checkbox"/> Cell culture only * <input type="checkbox"/> Chromosome breakage study (5-10 ml blood in sodium heparin (Green top) tube)	<input type="checkbox"/> t(9;22) [BCR/ABL1] <input type="checkbox"/> t(15;17) [PML/RAR α] <input type="checkbox"/> 11q23 [MLL] <input type="checkbox"/> X/Y [Opposite sex BMT] <input type="checkbox"/> Other (please call lab)
	FISH panels (all probes available individually as well) <input type="checkbox"/> ALL Hyperdiploid panel [trisomy 4,10,17] <input type="checkbox"/> ALL Risk Stratification panel [4,10,17; t(12;21); t(9;22);11q23 (MLL)] <input type="checkbox"/> AML panel [t(8;21); 11q23(MLL); inv(16)] <input type="checkbox"/> APL panel [t(15;17); RAR α] <input type="checkbox"/> Burkitt lymphoma panel [t(8;14); 8q24 (C-MYC)] <input type="checkbox"/> CLL panel [13q14.3; 13q34; 12 centromere; ATM(11q22.3); p53] <input type="checkbox"/> Fanconi anemia panel [1q25; 3q27; monosomy 7 / del(7q)] <input type="checkbox"/> Multiple myeloma panel [t(4;14);t(11;14); monosomy 13/del 13q;t(14;16);p53] <input type="checkbox"/> Myeloid disorder panel [mono 5/del 5q; mono 7/del 7q; tri 8; del (20q)] <input type="checkbox"/> SDS panel [mono 7/del 7q; tri 8; del (20q)] <input type="checkbox"/> Large cell NHL panel [2p23.2; t(11;14); t(14;18);17p13 (p53)] <input type="checkbox"/> Small B-cell NHL panel [CLL panel; t(11;14); t(14;18);18q21] <input type="checkbox"/> Combined NHL Panel (large and small cell)

Medical Necessity Regulations - At the government's request, the Genetics Laboratory would like to remind all physicians that when ordering tests that will be paid under federal health care programs, including Medicare and Medicaid, that these programs will pay only for those tests the relevant program deems to be (1) included as covered services (2) reasonable (3) medically necessary for the treatment and diagnosis of the patient (4) not for screening purposes. 2/2011

Please complete billing information on page 2. Both pages of requisition must be completed before sample can be processed.

Billing Information

Patient Name Last/First
DOB



Cincinnati Children's Hospital
Medical Center
3333 Burnett Avenue
Cincinnati, OH
45229

Choose one method of payment

Patient Billing

- Check Enclosed Money Order Credit Card
(Visa, MC, AM.Exp., Disc.)

Credit Card Number
Card Holder Name
Expiration Date
Signature

Phone: 513-636-4474

Fax: 513-636-4373

www.cincinnatichildrens.org

Referring Institution or MD

Institution
Address
City/State/Zip
Contact Name
Phone
Fax
Email

Insurance / Policy Holder Information

Name	
DOB	Gender
Authorization Number	
Insurance Name	
Insurance Address	
City/State/Zip	
Insurance ID Number	
Group Number	
Insurance Phone Number	

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Patient signed completed ABN

ALL INFORMATION MUST BE COMPLETED BEFORE SAMPLE CAN BE PROCESSED