

Place your institution's 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

Bill: Patient Physician/Institution Account
 Patient requests insurance to be billed Patient signed completed ABN

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 Physician phone # Physician fax #

Email: Physician Address

Lab Address Physician's signature (required)

Please review carefully. Complete all 3 sections below AND complete attached billing info sheet

Specimen Information

Bone marrow Oncology blood Lymph node Solid Tumor (specify) Paraffin Embedded Tissue Other (Specify)

WBC _____ **% Blasts** _____ Pre-transplant Post transplant Specify here _____

Disease status: New leukemia Remission Relapse (E)COG Study Known Down syndrome Primary solid tumor Metastatic tumor

Suspected Diagnosis / Indications (REQUIRED)

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

Test Requested

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

- Molecular analysis for leukemia translocation STR = VNTR
 BCR/ABL - t(9;22) by RT-PCR (QUALITATIVE) 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
 Pre-transplant host sample Post transplant sample Donor sample
 Special Study: Bone marrow engraftment (WBC sub-populations) STR FISH

You MUST call 513-636-4685 or 513-636-8657 to schedule this test!

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

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

Cytogenetic Test (3 ml bone marrow or blood in sodium heparin tube - green top)

If in media, type: _____

- Chromosome Analysis only
 Chromosome Analysis and FISH
 FISH only
 Constitutional (blood)
 Chromosome Analysis
 Cell culture only

FISH (Fluorescence In Situ Hybridization) - Specify below - This is not a complete list of available FISH probes;

- t(9;22) [BCR/ABL1]
 t(15;17) [PML/RAR α]
 11q23 [MLL]
 X/Y [Opposite sex BMT]
 Other (please call lab) _____

FISH panels (all probes available individually as well)

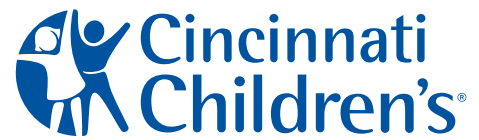
- ALL Hyperdiploid panel [trisomy 4,10,17]
 ALL Risk Stratification panel [4,10,17; t(12;21); t(9;22);11q23 (MLL)]

- AML panel [t(8;21); 11q23(MLL); inv(16)
 APL panel [t(15;17); RAR α]
 Burkitt lymphoma panel [t(8;14); 8q24 (C-MYC)]
 CLL panel [13q14.3; 13q34; 12 centromere; ATM(11q22.3); p53]
 Fanconi anemia panel [1q25; 3q27; monosomy 7 / del(7q)]
 Multiple myeloma panel [t(4;14);t(11;14); monosomy 13/del 13q;t(14;16);p53]
 Myeloid disorder panel [mono 5/del 5q; mono 7/del 7q; tri 8; del (20q)]
 SDS panel [mono 7/del 7q; tri 8; del (20q)]
 Large cell NHL panel [2p23.2; t(11;14); t(14;18);17p13 (p53)]
 Small B-cell NHL panel [CLL panel; t(11;14); t(14;18);18q21]
 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.

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*****