

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

**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-adult) (204.00)     | <input type="checkbox"/> Lymphoproliferative disorder (238.7)                   |
| <input type="checkbox"/> Acute lymphocytic leukemia (ALL-pediatric) (204.00) | <input type="checkbox"/> Monoclonal Gammopathy (273.1)                          |
| <input type="checkbox"/> Acute monocytic leukemia (206.00)                   | <input type="checkbox"/> Multiple myeloma (203.00)                              |
| <input type="checkbox"/> Acute myelocytic leukemia (AML) (205.00)            | <input type="checkbox"/> Myelodysplastic Syndrome (238.7)                       |
| <input type="checkbox"/> Acute promyelocytic leukemia (APL) (205.00)         | <input type="checkbox"/> Myelofibrosis (289.8)                                  |
| <input type="checkbox"/> Anemia (suspected leukemia) (285.9, 208.80)         | <input type="checkbox"/> Myeloma (203.0)  |
| <input type="checkbox"/> Burkitt's Lymphoma (200.20)                         | <input type="checkbox"/> Myeloproliferative Syndrome (238.7)                    |
| <input type="checkbox"/> Chronic myelogenous leukemia (CML) (205.10)         | <input type="checkbox"/> Neutropenia (suspected leukemia) (288.0, 208.80)       |
| <input type="checkbox"/> Chronic lymphocytic leukemia (CLL) (204.10)         | <input type="checkbox"/> Non-Hodgkin's Lymphoma (202.80)                        |
| <input type="checkbox"/> Hodgkin's Lymphoma (201.9)                          | <input type="checkbox"/> Pancytopenia (suspected leukemia) (284.0, 208.80)      |
| <input type="checkbox"/> Leukocytosis (suspected leukemia) (288.8, 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"/> Sarcoma (171.9)  |
| <input type="checkbox"/> Leukemia (known or suspected) (208.80)              | <input type="checkbox"/> Thrombocytopenia (suspected leukemia) (287.5, 208.80)  |
| <input type="checkbox"/> Lymphoma (202.80)                                   | <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: (use Green Top tube)**

- Chromosome Analysis only  
 Chromosome Analysis and FISH (check box and choose FISH test below)  
 FISH ONLY (check box and **choose FISH test below**) (cytogenetic analysis is usually required on bone marrows)

**FISH: (use Green Top tube) ★  FISH for previous abnormality ★**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> t(4;14) (Myeloma)                 | <input type="checkbox"/> t(15;17), PML-RARA (APL)                           | <input type="checkbox"/> Multiple Myeloma (13q,17p,14q) |
| <input type="checkbox"/> t(8;14) (Burkitt's lymphoma)      | <input type="checkbox"/> CLL (13q,11q,17p, trisomy 12)                      | <input type="checkbox"/> MLL involvement (11q23)        |
| <input type="checkbox"/> t(9;22) (BCR-ABL for CML and ALL) | <input type="checkbox"/> Deletion 5q  | <input type="checkbox"/> t(14;18) (Lymphoma)            |
| <input type="checkbox"/> t(11;14) (Lymphoma)               | <input type="checkbox"/> Deletion 7q (Monosomy 7)                           | <input type="checkbox"/> Pre-B ALL Panel                |
| <input type="checkbox"/> t(11;22) (Ewing Sarcoma)          | <input type="checkbox"/> Deletion 13q                                       |   |
| <input type="checkbox"/> t(12;21) (TEL/AML1)               | <input type="checkbox"/> Inverted 16; t(16;16)/del 16 (AML-M <sub>4</sub> ) | <input type="checkbox"/> Other _____                    |

**Molecular: (Use 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 BCR-ABL |
| <input type="checkbox"/> Prothrombin (ICD9=286.3)     | <input type="checkbox"/> Hereditary Hemochromatosis             | <input type="checkbox"/> JAK2                         |
| <input type="checkbox"/> MTHFR (ICD9=286.3)           | <input type="checkbox"/> DNA Extract and Store                  | <input type="checkbox"/> Other _____                  |

**Pre-Transplant:**

**-- CHIMERISM STUDY --**

**Post-Transplant:**

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