Washington University Physicians®

Clinical Genomics Laboratory - Cytogenetics: Cancer

Shipping Address

Washington University Pathology Services
Clinical Genomics Laboratory
660 S. Euclid Ave. | Campus Box 8118 | St. Louis MO 63110 Tel: (314) 454-8101 | Fax: (314) 362-8296
On-Call Pager: (314) 407-0269

Sample drop-off locations:

Clinical Support Office
509 S. Euclid Ave.
4th Floor West Bldg, Room 4711
St. Louis, MO 63110
Tel: (314) 454-8101
(8:00am - 5:00pm)

Institute of Health (IOH) Core Lab
425 S. Euclid Ave., Room 4701
St. Louis, MO 63110
Tel: (314) 362-1470
AFTER HOURS

Office use only
Date/Time Received:
Accession Number:
Technician Initial:

This requisition has two pages, please complete it completely and accurately.

PATIENT IDENTIFICATION					PHYSICIAN ORDER TEST (NPI required)		
Name Last:	First:			MI:	Name Last:	First:	MI:
DOB (mm/dd/yyyy):	Sex:	Male:	Female:		NPI:	Email:	
Medical Record # (if applicable):					Phone:	Fax:	
Address:					Address:		
City:	State:		Zip:		City:	State:	Zip:

SPECIMEN (check one)

Date Specimen Collected:

☐ Peripheral Blood ☐ Bone Marrow ☐ Bone Core ☐ Solid Tumor ☐ Lymph Node

Tissue Biopsy, specify:

CLINICAL INFORMATION

Clinical Diagnosis (lymphocytic leukemias and lymphomas, please indicate if B or T cell):				ICD10 Code:
				WBC%:
Disease Status:	☐ New Diagnosis	☐ Relapse	☐ Remission	Circulating Blasts:
Post: BMT/SCT:	☐ Autologous	☐ Male Donor	☐ Female Donor	Immunophenotype:

TESTING REQUESTED (check all that apply)

Chromosome Analysis/ Karyotype

Fluorescence In-Situ Hybridyzation (Chromosome abnormality/Probe Loci are indicated. *denotes probes available but not included in panel)

AML Panel
- ☐ t(15;17) - *PML/RARA*
- ☐ t(v;17) - *RARA**
- ☐ t(8;21) - *RUNX1/RUNX1T1*
- ☐ inv(16) - *CBFB*
- ☐ 11q23 - *KMT2A* (MLL)
- ☐ +8 - CEP 8
- ☐ -7/del(7) - D7S486
- ☐ -5/del(5) - *EGR1*
- ☐ 3q26 - *MECOM* (EVI1)
- ☐ *NUP98* - 11p15.4 (patient <50)

Mantle Cell
- ☐ t(11;14) - *CCND1/IGH*

SCLL
- ☐ 8p12 - *FGFR1*

B-cell ALL Panel
- ☐ t(12;21) - *ETV6/RUNX1*
- ☐ 11q23 - *KMT2A* (MLL)
- ☐ Hyper/Hypo-diploid - *CEP* 4,10,17
- ☐ t(1;19)/t(17;19) - *TCF3*
- ☐ t(9;22) - *BCR/ABL1*
- ☐ del(9)(p21) - *CDKN2A*
- ☐ 14q32 - *IGH*
- ☐ *CRLF2* – Xp/Yp rearrangement
- ☐ *ABL1* – 9q34.12
- ☐ *ABL2* – 1q25.2
- ☐ *PDGFRB* – 5q32-33

MDS Panel
- ☐ -7/del(7) - D7S486
- ☐ -5/del(5) - *EGR1*
- ☐ del20q - D20S108
- ☐ 12p13 - *ETV6*
- ☐ +8 - CEP 8
- ☐ del13q - D13S319

CLL Panel
- ☐ +12 - *CEP 12*
- ☐ del13q - D13S319
- ☐ 11q22.3 - *ATM*
- ☐ 17p13 - *TP53*
- ☐ t(11;14) - *CCND1/IGH*
- ☐ 3q27 - *BCL6*
- ☐ 6q23 - *MYB**
- ☐ 18q21 - *BCL2**

Multiple Myeloma Panel
- ☐ del13q - D13S319
- ☐ t(4;14) - *FGFR3/IGH*
- ☐ 17p13 - *TP53*
- ☐ 1p32.3/1q21 - *CKS1B/CDKN2C*
- ☐ t(14;16) - *IGH/MAF*
- ☐ t(11;14) - *CCND1/IGH*

T-cell ALL Panel
- ☐ 14q11 - *TCR(TRA/D)*
- ☐ 7q34 - *TRB*
- ☐ 11q23 - *KMT2A* (MLL)
- ☐ 9p21 - *CDKN2A*

MPN Panel
- ☐ *CHIC2*/del 4q12 - *FIP1L1/PDGFRA*
- ☐ *BCR/ABL1* – t(9;22)
- ☐ *PDGFRB* – 5q32-33
- ☐ *FGFR1* – 8p12

Anaplastic
- ☐ 2p23 - *ALK*

Lymphoma Panel
- ☐ 14q32 - *IGH*
- ☐ 3q27 - *BCL6**
- ☐ 8q24 - *MYC*

Burkitt's Panel
- ☐ t(8;14) - *MYC/IGH*/CEP 8
- ☐ 8q24 - *MYC*

Diffuse Large Cell
- ☐ t(14;18) - *IGH/BCL2*

MALT Panel
- ☐ 18q21 - *MALT1*
- ☐ t(11;18)-*BIRC3/MALT1*
- ☐ t(14;18) - *IGH/MALT**

Sex Mismatch Transplant
- ☐ *CEP X/Y*

CMML
- ☐ 5q32-33 - *PDGFRB*

CML
- ☐ t(9;22) - *BCR/ABL1*

REFERRING PHYSICIANS (Name, address, and contact information of ordering physician is required. Residents must include attending physician contact information)

Doctor:

Address:

Tel:	Fax:	Pager:

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PATIENT INFORMATION

Last Name:	First Name:	MI:	DOB (mm/dd/yyyy):

INSURANCE AND PRECERTIFICATION

Patients are responsible for non-covered services, deductibles, co-insurance, contract exclusions, non-authorized services, and remaining balances after insurance reimbursement. Washington University School of Medicine can only accept authorized Missouri and Illinois MEDICAID covered charges for genetic testing. Other out-of-state welfare programs cannot be billed. Please contact our Patient Accounts Manager office at 314-362-5641 or via e-mail at path-billing@email.wustl.edu for complete insurance filing information and the managed care contract list.

Prior Authorization Number:	ICD10 Code(s):
CPT Codes and Units Authorized:	

ATTACH COPY OF INSURANCE CARD (if not available, complete the following)

Policy Holder's Name: Last First MI	Insurance Co. Name:	
	Insurance Co. Phone:	
Policy Holder's Date of Birth (mm/dd/yyyy):	Plan Name:	
Relationship to patient:	ID#:	Group#:

SELF-PAY / PATIENT FINANCIAL ASSISTANCE

Patients who are self-pay should contact our office to arrange for payment. Financial assistance may be available. For more information, contact our Patient Accounts Manager office at 314-362-5641 or via e-mail at path-billing@email.wustl.edu.

Reference Laboratories: complete section below

INSTITUTIONAL BILLING

Institution Name:		
Contact Name:		
Email:		
Billing Address:		
City:	State:	Zip:
Phone:	Fax:	