Washington University Physicians® Clinical Genomics Laboratory - Cytogenetics: Cancer FFPE FISH

Shipping Address

Washington University Pathology Services
Clinical Support Office
425 S. Euclid, Room 4701
MSC 8024-14-4711
St. Louis, MO 63110

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 INFORMATION

Date of biopsy:

Date of transplant:

Paraffin Embedded Tissue
- Minimum # of unstained slides = 3 per test ordered
- Cut at 4~5 microns on positively charged slides
- Slides should be stored/ sent overnight at ambient temperature
- Must be fixed in 10% neutral buffered formalin
- Preferred fixation duration for tissue samples is 6-48 hours

Accompanying Materials
- Pathologist-marked H&E slide identifying area(s) of interest
- Patient pathology report

NOTE: The specimen slide(s) for testing should be within 10 serial sections of the provide H&E slide to ensure the presence of the lesional area of interest.

REASON FOR TESTING (required, failure to include diagnosis may delay testing)

Diagnosis:

ICD10 Code(s):

TESTING REQUESTED (check all that apply)

Breast Cancer

☐ *ERBB2* (PathVysion *HER2*/neu)	17q11.2-q12/17cen

Strict adherence to ASCO guidelines for min/max fixation times and type is required for *HER2* testing

Hematologic Malignancies

☐ *C-MYC* Break apart	8q24
☐ t(14;18) – *IGH::BCL2*	14q32 / 18q21
☐ *BCL6* Break apart	3q27
☐ t(11;14) – *IGH::CCND1*	14q32 / 11q13
☐ t(9;22) – *BCR::ABL1*	22q11.2 / 9q34
☐ t(11;18) – *BIRC3::MALT1*	11q22 / 18q21
☐ *KMT2A* (MLL) Break apart	11q23
☐ *IgH* Break apart	14q32
☐ *ALK* Break apart	2p23

Sarcomas

☐ *DDIT3* Break apart (*CHOP*)	12q13
☐ *FOXO1* Break apart (*FKHR*)	13q14
☐ *FUS* Break apart	16p11
☐ *SS18* Break apart	18q11.2
☐ *EWSR1* Break apart	22q12
☐ *MDM2* Amplification (*MDM2*/C12)	12q15/12 cen

Lung Cancer

☐ *ALK* Rearrangement (IVD) for NSCLC	2p23
☐ *CEP7* / *EGFR* Amplification	7cen / 7p12
☐ *ROS1* Break apart	6q22
☐ *RET* Break apart	10q11
☐ *CEP7* / *MET* Amplification	7q31.2
☐ *CEP8* / *FGFR1* Amplification	

Neuropathologic Malignancies

☐ 1p36/1q25 Deletion	1p36 / 1q25
☐ 19p13/19q13 Deletion	19p13 / 19q13
☐ *EGFR* Amplification (*CEP7* / *EGFR*)	7 cen / 7p12
☐ Loss of 10q (*PTEN* / *CEP10*)	10q23 / 10cen
☐ Loss of 14q	14q32
☐ Loss of 22q	22q12
☐ Loss of *CDKN2A (p16)*	9 cen / 9p21
☐ *N-MYC* Amplification *(N-MYC* / *CEP2)*	2p24 / 2cen
☐ *C-MYC* Amplification (*C-MYC* / CEP8)	8 cen / 8q24.12-q24.13
☐ *BRAF::KIAA1549*	7q34
☐ *ERBB2 (HER2)* for 17q gain	7q11.2-q12 / 17cen

Other

☐ *USP6* Break apart	17p13.2
☐ *MAML2* Break apart	11q21

ADDITIONAL NOTES:

Healthcare Professional Signature to Authorize Testing and Statement of Medical Necessity
I certify that the patient specified above and/or their legal guardian has been informed of the benefits, risks, and limitations of the laboratory test(s) requested and Informed Consent has been obtained, as well as any other consent from the patient required by my state in order to perform a genetic test on a specimen has been obtained. I further certify that the test(s) requested is/are medically necessary and the results of this test will be used in the medical management of the patient.

Signature:

Date:

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:	