WashU Medicine

Clinical Genomics Laboratory - Cytogenetics: Cancer

Shipping Address

Washington University Pathology Services
Clinical Support Office
425 S. Euclid Ave., 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 both pages to ensure testing.

PATIENT IDENTIFICATION

Patient Status: ☐ Inpatient ☐ Outpatient ☐ Office Visit

Name Last: | First: | MI:

DOB (mm/dd/yyyy): | Sex: ☐ Male ☐ Female

Medical Record # (if applicable):

Address:

City: | State: | Zip:

Ethnicity (select all that apply)

☐ African American ☐ Asian ☐ Caucasian/NW European
☐ E Indian ☐ Hispanic ☐ Jewish-Ashkenazi ☐ Jewish-Sephardic
☐ Mediterranean ☐ Native Hawaiian/Pacific Islander ☐ Other

PHYSICIAN Ordering TEST *(NPI required)*

Name:

Institution:

NPI: | Email: doc email 1

Address:

City: | State: | Zip:

Phone: | Fax:

Alternative Contact Information:

Phone: | Email:

Notes:

SPECIMEN (check one)

Date Specimen Collected: specimen date

☐ 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%:
Circulating Blasts:
Immunophenotype:

Disease Status: ☐ New Diagnosis ☐ Relapse ☐ Remission

Post: BMT/SCT: ☐ Autologous ☐ Male Donor ☐ Female Donor

TESTING REQUESTED (check all that apply)

Chromosome Analysis/ Karyotype ☐ **FISH per algorithm** ☐

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)
- ☐ 11p15.4-*NUP98* (patient <50)
- ☐ t(9;22) - *BCR::ABL1*

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*
- ☐ Xp/Yp rearrangement - *CRLF2*
- ☐ 9q34.12 - *ABL1*
- ☐ 1q25.2 - *ABL2*
- ☐ 5q32-33 - *PDGFRB*

MDS Panel
- ☐ -7/del(7) - D7S486
- ☐ -5/del(5) - *EGR1*
- ☐ del20q - D20S108
- ☐ 12p13 - *ETV6*
- ☐ +8 - CEP 8
- ☐ del13q - D13S319
- ☐ 17p13 - *TP53*

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

Anaplastic
- ☐ 2p23 - *ALK*

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

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

Waldenstrom Macroglobulinemia Panel
- ☐ 6q23 - *MYB*
- ☐ 11q22.3 - *ATM*/CEP11
- ☐ del13q - D13S319/*LAMP1*
- ☐ 17p13 - *TP53*
- ☐ CEP 4

Diffuse Large Cell
- ☐ 6p25 - *IRF4*
- ☐ t(14;18) - *IGH::BCL2*
- ☐ 8q24 - *MYC*
- ☐ 3q27 - *BCL6*

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

Sex Mismatch Transplant
- ☐ *SRY*/CEP X/CEP 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:

PATIENT INFORMATION

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

BILLING INFORMATION
(CHECK ONE)

☐ **Bill Patient/Insurance-Complete Section A** ☐ **Bill Submitting Institution-Complete Section B**

SECTION A-PATIENT/INSURANCE BILLING INFORMATION

Patients are responsible for non-covered services, deductibles, co-insurance, contract exclusions, non-authorized services, and remaining balances after insurance reimbursement. For MEDICAID patients, Washington University School of Medicine can only accept authorized Missouri and Illinois MEDICAID covered services. Other out-of-state welfare programs cannot be billed. Please contact our Patient Accounts Manager office at (314) 362-5641 or via email 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 Unit Authorized:	

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

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

SECTION B-INSTITUTIONAL BILLING

Institution Name:		
Contact Name:	PO Number (if applicable):	
Email:		
Accounts Payable Billing Address:		
City:	State:	ZIP:
Phone:	Fax:	