Washington University Physicians
Washington University School of Medicine in St. Louis

CYTOGENETICS: Cancer FFPE FISH

Cytogenetics and Molecular Pathology Laboratory

Division of Laboratory and Genomic Medicine
Department of Pathology & Immunology
660 S. Euclid Ave., Campus Box 8118, St. Louis MO 63110
Tel: (314) 454-8101 | Fax: (314) 362-4080
On-Call Pager: (314) 407-0269

Sample drop-off locations:

Children's Hospital
One Children's Place
Central Receiving 2N-25
St. Louis, MO 63110
Tel: (314) 454-4161

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

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

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

PHYSICIAN ORDER TEST (NPI required)			**PATIENT IDENTIFICATION**		
Name:			Name Last:	First	MI:
NPI:	Email:		DOB (mm/dd/yyyy):	Gender: Male Female	
Phone:	Fax:		Medical Record # (if applicable):		
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 provided 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

Test	Locus
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

Test	Locus
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 / ABL*	22q11.2 / 9q34
t(11;18) – *BIRC3 / MALT1*	11q22 / 18q21
KMT2A (MLL) Break apart	11q23
IgH Break apart	14q32
ALK Break apart	2p23

Sarcomas

Test	Locus
DDIT3 Break apart *(CHOP)*	12q13
FOXO1 Break apart *(FKHR)*	13q14
FUS Break apart	16p11
SS18 Break apart	18q11.2
EWSR1 Break apart	22q12

Lung Cancer

Test	Locus
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	8p12

Neuropathologic Malignancies

Test	Locus
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

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:	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#:

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.

AUTHORIZATION TO ASSIGN BENEFITS AND ACCEPT FINANCIAL RESPONSIBILITY FOR ACCOUNT

I authorize the disclosure of insurance benefit coverage and payment information to Washington University School of Medicine. I authorize Washington University School of Medicine to furnish any medical information requested on myself, or my covered dependents. I assign and authorize insurance payments to Washington University School of Medicine. I understand I am responsible for any co-pay, deductibles, or non-authorized services and remaining balances after insurance reimbursement. I understand I am fully responsible for payment of my account if Washington University School of Medicine is not a participant with my health plan, and/or my health plan does not fully reimburse medical services due to lack of authorization or medical necessity.

Signature of Patient or Guardian	Printed Name of Patient or Guardian	Date

Reference Laboratories: complete section below

INSTITUTIONAL BILLING

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