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

CYTOGENETICS: Cancer

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.

HOSPITAL STAMP

Date Specimen Collected:
Hospital Unit#:
IMPORTANT: Studies cannot be completed without adequate patient identification and clinical information

PATIENT IDENTIFICATION

Name Last:	First:	MI:
DOB (mm/dd/yyyy):	Gender ◯ Male ◯ Female	
Address:		
City:	State:	Zip:

SPECIMEN (check one)

◯ Bone Marrow ◯ Bone Core ◯ Lymph node
◯ Peripheral Blood ◯ Solid Tumor
◯ 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 - *MLL (KMT2A)*
- ☐ +8 - *CEP 8*
- ☐ -7/del(7) - *D7S486*
- ☐ -5/del(5) - *EGR1*
- ☐ 3q26 - *EVI**

☐ **B-cell ALL Panel**
- ☐ t(12;21) - *ETV6/RUNX1*
- ☐ t(9;22) - *BCR/ABL*
- ☐ 11q23 - *MLL (KMT2A)*
- ☐ Hyper/Hypo-diploid - *CEP 4,10,17*
- ☐ t(1;19)/t(17;19) - *TCF3*
- ☐ del(9)(p21) - *CDKN2A*
- ☐ 14q32 - *IGH*

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

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

☐ **CML/MPD Panel**
- ☐ t(9;22) - *BCR/ABL1*
- ☐ CHIC2/del 4q12 - *FIP1L1/PDGFRA*

CMML
- ☐ 5q32-33 - *PDGFRB*

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

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

Sex Mismatch Transplant
- ☐ CEP X/Y

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

Anaplastic
- ☐ 2p23 - *ALK*

☐ **Burkitt's Panel**
- ☐ t(8;14) - *MYC/IGH/CEP8*
- ☐ 8q24 - *MYC*

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

☐ **MALT Panel**
- ☐ 18q21 - *MALT1*
- ☐ t(11;18) - *API2/MALT1*
- ☐ t(14;18) - *IGH/MALT**

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

SCLL
- ☐ 8p12 - *FGFR1*

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

Doctor:			Doctor:		
Address:			Address:		
Tel:	Fax:	Pager:	Tel:	Fax:	Pager:

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:	