# CYTOGENETICS TESTING SERVICES REQUISITION

*The space above this line is for laboratory use only.*

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Date & Time Collected

Date & Time Received (Lab Use)

Ordering Physician / Client

Signature of Requesting Physician (Required)

| Patient Name | Last | First |
|---|---|---|
| Address | | |
| City State Zip | | |
| D.O.B. | | Sex | | Phone | |

| ICD-10 Code (Mandatory) | ICD-10 Code | ICD-10 Code | ICD-10 Code |
|---|---|---|---|
| | | | |

COPY OF REPORT TO: **(FAX NUMBER MUST BE PROVIDED)**

| NAME | FAX # |
|---|---|
| NAME | FAX # |

Please label all specimens with the patient's full name. Provide patient's clinical history and other relevant information as appropriate. This is a requirement of the NYSDOH.

**BILLING**

☐ Insurance ☐ Patient ☐ Client

PRIMARY INSURANCE INFORMATION

Insurance Company

Contract/ID/Policy # | Group #

Name of Insured

SECONDARY INSURANCE INFORMATION

Insurance Company

Contract/ID/Policy # | Group #

Name of Insured

## Relevant Clinical History

## Type Of Specimen

☐ Peripheral Blood* ☐ Bone Marrow*

WBC count:

*** Please send a copy of the most recent CBC and differential**

☐ Tissue

Site:

Fixation time:

Ischemic time:
(Required for breast and gastric cx)

## Testing Requested

### Chromosome Analysis (Karyotype): ☐ **Cancer cytogenetics** ☐ **Constitutional cytogenetics** •

- For NYS patients, informed consent is required for non-oncology cytogenetics testing. Please complete back of requisition.

### FISH for Hematopoietic Disorders:

**Chronic Lymphocytic Leukemia**

☐ CLL Panel (ATM, +12, del (13q), TP53, IGH/CCND1)

** Specimen type: Bone marrow or peripheral blood*

**Chronic Myeloid Leukemia/ Myeloproliferative Neoplasms**

☐ BCR/ABL1 t(9;22)

** Specimen type: Bone marrow or peripheral blood*

**Plasma Cell Neoplasms**

☐ Multiple Myeloma Panel (CKS1B/CDKN2C, del(13q)/-13, TP53, +3, +7, +9, +15, IGH, reflex to IGH/CCND1, IGH/FGFR3, IGH/MAF, IGH/MAFB)

** Specimen type: Bone marrow*

**Myelodysplastic Syndrome/Acute Myeloid Leukemia**

☐ MDS Panel (EVI1, del(5q)/-5, del(7q)/-7, +8, MLL, del(20q)/-20)
☐ AML Panel (RUNX1/RUNX1T1, CBFB/MYH11, PML/RARA, BCR/ABL1, del(13q), TP53, EVI1, del(5q)/-5, del(7q)/-7, +8, MLL, del(20q)/-20)
☐ RUNX1/RUNX1T1 t(8;21)
☐ CBFB/MYH11 inv(16) or t(16;16)
☐ PML/RARA t(15;17)

** Specimen type: Bone marrow or peripheral blood*

**High Grade B-cell Lymphoma**

☐ HGBCL Panel (MYC, BCL2, BCL6)
☐ MYC
☐ BCL2
☐ BCL6

** Specimen type: FFPE*

**Follicular Lymphoma**

☐ IGH/BCL2 t(14;18)

** Specimen type: Bone marrow or peripheral blood or FFPE*

**Mantle Cell Lymphoma**

☐ IGH/CCND1 t(11;14)

** Specimen type: Bone marrow or Peripheral blood*

### FISH for Solid Tumor:

**Breast Cancer**

☐ HER2/neu

**Gastric Cancer**

☐ HER2/neu

**Lung Adenocarcinoma**

☐ ALK
☐ ROS1

**Lipomatous neoplasms**

☐ MDM2

## Additional Instructions: