SHODAIR CHILDREN'S HOSPITAL GENETICS LABORATORY
2755 Colonial Dr, Helena. MT, 59601 (406) 444-7532 (800) 447-6614
Fax (406) 444-1022, Email: mtgene@shodair.org

SHODAIR LAB #:

ONCOLOGY TEST REQUEST FORM

(*Please send this completed form with the specimen*)

PATIENT LAST NAME: ______________________________ **FIRST NAME :** _______________ **SOC. SEC. #:** _______________

DOB: ____/____/____ **SEX:** M / F / Unk **REF. LAB #:** _______________ **DATE COLLECTED:** ___/___/___ **DATE RECEIVED:** ___/___/___

Resp. Party (Relation to Pt): _________________________ Address: ____________________________ Phone: (_____)__________

ETHNIC BACKGROUND: (Circle all that apply) European Caucasian, Hispanic, Native American, African American, Asian, Other

REFERRING PHYSICIAN/ HEALTH PROFESSIONAL:
Name: ______________________________
Address: ______________________________
City, State, Zip: ______________________________
Telephone:(_____)__________ FAX:(_____)__________

REFERRING INSTITUTION / CLINIC / LABORATORY:
Name: ______________________________
Address: ______________________________
City, State, Zip: ______________________________
Telephone:(_____)__________ FAX:(_____)__________

ADDITIONAL REPORTS TO:
Name: ______________________________
Address: ______________________________
City, State, Zip: ______________________________
Telephone: (_____)__________ FAX: (____)__________

BILLING INFORMATION: (Check)

❑ **REFERRING INSTITUTION / CLINIC / OFFICE**
Institution Name: _________________________ Inpatient: Yes No
Billing Address: ______________________________
Financial Contact: ____________________ Telephone: (_____)________

❑ **INSURANCE**
Commercial: Provide front / back copy of card
Managed Care (HMO): Copy of card with authorization
Medicaid (MT, WY, CO, UT, CA, ID): Copy of card
Name of Policy Holder: ______________________________
Insurance Co / Policy #: ______________________________
Insurance Co Contact / Phone #: ______________________________
SS # (Guarantor): ______________________________
Medicaid # / State: ______________________________

❑ **SELF PAY** (Please call the laboratory to arrange)

INDICATION FOR ANALYSIS:

❑ **Possible/Probable diagnosis: list symptoms**

❑ **ICD-9 Codes:** ____________: ____________

SPECIMEN TYPE: (Please check) PLEASE NOTIFY THE LABORATORY WHEN A SPECIMEN IS BEING SENT. 1-800-447-6614, EXT. 7532

❑ **Bone Marrow: Sodium Heparin (green top tube) 5 ml, room temp**

❑ **Oncology Peripheral Blood: Sodium Heparin (green top tube) 5 ml, room temp**

❑ **Fixed tissue, source:** ______________

TEST REQUESTED: (Please check one or more; test descriptions with CPT codes and prices faxed on request).

❑ **Chromosomes**

❑ **HER2/neu *FISH***

❑ **Bladder Cancer Aneuploidy *FISH***

❑ **Other:** ____________

❑ **Chromosomes + *FISH***

- ❑ **BCR/ABL (t9;22)**
- ❑ **PML/RARA (t15;17)**
- ❑ **EGR 1/CSFIR (5q-)**
- ❑ **D13S25/D13S319 (del 13 in CLL)**
- ❑ **CEP 12**
- ❑ **CEP 8**
- ❑ **CEP X/Y (engraftment)**
- ❑ **D20S108 (20q-)**
- ❑ **ALK (t2;5)**
- ❑ **TEL/AML 1 (t12/21/)**
- ❑ **RB-1 (del13q)**
- ❑ **p53 (17p)**
- ❑ **N-myc (2p)**
- ❑ **C-myc (8q)**
- ❑ **11q23**
- ❑ **Other probes available, please contact lab for info**

LAB USE ONLY:

Date Collected: ____/____/____
Date Received: ____/____/____
Date Set Up: ____/____/____

Med. Rec. #____________________
Admit #____________________
Shire #____________________

Lab #