

SHODAIR LAB #:

ONCOLOGY TEST REQUEST FORM

(Please send this completed form with the specimen)

PATIENT LAST NAME: _____ FIRST NAME : _____ DOB: _____
 SEX: M / F REF. LAB #: _____ DATE COLLECTED: _____ DATE RECEIVED: _____
 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: _____ ADDITIONAL REPORTS TO: Name: _____
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PHYSICIAN SIGNATURE: _____ **Date:** _____
 (required for Medicare / Medicaid billing)

BILLING INFORMATION: <input type="checkbox"/> REFERRING INSTITUTION New clients please call laboratory with financial contact information.	<input type="checkbox"/> INSURANCE Name of policy holder: _____ Policy holder DOB: _____ SS # (Guarantor): _____ Address: _____ Phone #: _____ Relationship to patient: _____ Insurance Co. / Policy #: _____ Insurance Co Contact / Phone #: _____	<input type="checkbox"/> Medicaid #: _____ State (MT, WY, CO, UT): _____ SS#: _____ <input type="checkbox"/> SELF PAY <input type="checkbox"/> Inpatient
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INDICATION FOR ANALYSIS

Possible / Probable diagnosis: list symptoms

ICD-9 Codes:

Bone Marrow: (leukemia/lymphoma)

Suspected/Unknown

Previously Tested

SPECIMEN TYPE: (Please check) PLEASE NOTIFY THE LABORATORY WHEN A SPECIMEN IS BEING SENT.

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

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

Paraffin Embedded Tissue: _____

***NOTE:** FISH is possible on specimens drawn in EDTA or ACD tubes, but Na Heparin tubes give optimal results and are preferred

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

<input type="checkbox"/> Chromosomes (Cytogenetic Studies)	<input type="checkbox"/> Molecular Studies (FISH) +/- Chromosomes	<input type="checkbox"/> Burkitt's Lymphoma t(8:14); t2;8); t(8;22)	<input type="checkbox"/> AML Panel: -AML/ETO t(8:21) -PML/RARA t(15;17) -CBFB INV(16) -inv (3) RPN1/EV11
<input type="checkbox"/> Paraffin Embedded Tissues FISH	<input type="checkbox"/> BCR/ABL t(9;22)	<input type="checkbox"/> Mantle Cell Lymphoma t(11;14)	<input type="checkbox"/> MDS Probe Panel: -LSI 5 -LSI 7 -LSI 20 -LSI C-myc (8q) -inv(3) RPN1/EV11
	<input type="checkbox"/> PML/RARA t(15;17)	<input type="checkbox"/> Follicular Lymphoma t(14;18)	<input type="checkbox"/> Multiple Myeloma -PS1=p53,ATM.MYB-6q23 -PS2=LSI 13q, CEP 12 -PS3=LSI 5, CEP 9, CEP 15 (hyperdiploidy) -IGH rear
	<input type="checkbox"/> INV (16)	<input type="checkbox"/> MALT lymphoma t(11;18)	<input type="checkbox"/> CLL Probe Panel: -PS1=p53,ATM.MYB-6q23 -PS2=LSI 13q, CEP 12 -IGH rear
	<input type="checkbox"/> 11q23 (MLL)	<input type="checkbox"/> P53 (17p)	
	<input type="checkbox"/> CSFIR (5q-)	<input type="checkbox"/> CEP 8	
	<input type="checkbox"/> D20S108 (20q-)	<input type="checkbox"/> C-myc (8q)	
	<input type="checkbox"/> ALK t(2;5)	<input type="checkbox"/> CEP X/Y (engraftment)	
	<input type="checkbox"/> TEL/AML1 t(12;21)		
	<input type="checkbox"/> RB-1 (del13q)		

Other probes available, please contact lab for info

Med Red #: _____ Admit #: _____ Shire #: _____