8 Enterprise Lane, Oakdale CT-06370
Tel:(860)574-9172; Fax: (860)574-9264
Email: info@gdilabs.com

Oncology Requisition Form

CT-ST License # CL-0687

1: PATIENT INFORMATION

Billing #
Client #

Bill To: Must Check one ☐ **Clinic/Facility** ☐ **Insurance** ☐ **Patient(Self Pay)**

☐ MEDICARE SECONDARY PAYER INFORMATION REQUIRED. Medicare secondary status has been verified with beneficiary representative within 90 days of service and documentation is on file. ☐ MSP Collected

Date & Time Collected | Drawn By

SOCIAL SECURITY# | ☐Male ☐ Female | BIRTH DATE(Month/Day/Year)

PATIENT NAME (LAST) (FIRST) (M.I.) | Electronic Medical Record # | Hospital /Accession#

FOR STAT SAMPLES All or Single Test
☐ Call to (check below)
☐ Your facility
☐ Alternate Number
( )_____

PATIENT ADDRESS (STREET) | CITY | STATE | ZIP | PATIENT PHONE #

☐ MEDICARE PRIMARY ☐ MEDICARE SECONDARY

MEDICARE/MED. NUMBER | STATE

Clinical Indication for Testing

MEDICAL ASSISSTANCE NUMBER | STATE

POLICY HOLDER Name | POLICY HOLDER DATE OF BIRTH | MEMBER/POLICY # | GROUP #

Ordering Physician Name & Signature

RELATIONSHIP OF PATIENT TO INSURED
☐ SELF ☐ SPOUSE ☐ DEPENDENT

INSURANCE CO. NAME

Referring Physician

ICD9 DIAGNOSIS CODE(S) FOR TESTS ORDERED (MUST BE PROVIDED)

Genetic Counselor

Dx1 | Dx2 | Dx3 | Dx4

Phone | **Fax**

Medical Necessity Statement: Tests ordered on Medicare patients must follow CMS rules regarding medical necessity and FDA approval guidelines and must include diagnosis, symptoms and reason for testing as indicated in the medical record. If testing does not come under Medicare guidelines for payment a 'signed' Advanced Beneficiary Notice must be included.

2: SPECIMEN TYPE (in NaHep tube - Do Not Freeze) & INFORMATION

☐ BONE MARROW
☐ BONE CORE
☐ LYMPH NODE
☐ MALIGNANT TISSUE /MASS/TYPE_____ ☐ OTHER/SENDOUT
☐ PERIPHERAL BLOOD
☐ PARAFFIN SLIDES - Positively charged 3-4µ thick with accompanying marked H & E slide (2 slides per probe minimum)
☐ SKIN BIOPSY
WBC: _____ BLASTS: _____

3: FLOW CYTOMETRY ANALYSIS ☐ Yes ☐ No Please Check

Leukemia/Lymphoma/MDS/Myeloma evaluation by Cytometry: Available Antibody Panels:

Comprehensive Antibody Panel	CLL/SLL with prognostic panel
Acute Leukemia/Myelodysplasia	Plasma Cell Dyscrasia/Multiple Myeloma
Lymphoma/NHL	PNH panel with FLAER

4: IMMUNOHISTOCHEMISTRY ☐ Yes ☐ No Please Check

Estrogen, Progesterone Receptor Status; Her2/neu; Lymph Node Micrometastasis Detection (PCK); MIB-1 (Ki-67); HPV; P16-Cervical Biopsies; Ki-67 Cervical Biopsies

5: CHROMOSOME ANALYSIS ☐ Yes ☐ No Please Check

6: FISH STUDIES (circle one) → RUN or HOLD

HEMATOLOGY/ONCOLOGY FISH
☐ 5q31 (EGR1) deletion/-5 loss
☐ 7q31 del(7q)
☐ 20q12 del(20q)
☐ AML1/ETO (RUNX1T1/RUNX1) t(8;21)
☐ ATM /p53 deletion 11q22.3/17p13.1
☐ BCL6 3q27
☐ BCR/ABL1, PLUS t(9.22)
☐ CCND1/IGH t(11;14)
☐ CBFB/MYH11 16q22
☐ CEP 4 4p11.1-q11.1
☐ CEP 7 7p11.1-q11.1
☐ CEP 8 8p11.1-q11.1
☐ CEP 9 9p11.1-q11.1
☐ CEP 10 10p11.1-q11.1
☐ CEP 12 12p11.1-q11.1
☐ CEP 15 15p11.1-q11.1
☐ CEP 17 17p11.1-q11.1
☐ CHIC2 (PDGFRA) 4q12
☐ cMYC 8q24
☐ cMYC/IGH t(8;14)
☐ D13S319/13qter del13q14
☐ EVI1(MECOM) 3q26.2
☐ ETV/RUNX1(TEL/AML1) t(12;21)
☐ FGFR1 8p11.22-11.23
☐ FGFR3/IGH t(4;14)
☐ IGH 14q32
☐ IGH/BCL2 t(14;18)
☐ IGH/MAF t(14;16)
☐ MALT1 18q21
☐ MLL (KTM2A) 11q23
☐ MYB/CEP6 6q23
☐ P16(CDKN2A)deletion 9p21
☐ PML/RARα t(15;17)
☐ TCL1 14q32.13
☐ TCRAD 14q11

ONCOLOGY FISH PANELS

☐ **Acute lymphoblastic leukemia** ALL(ALLP)
B-cell __ T-Cell__
☐ **B-Cell (ALL)** Panel, recommended for pediatric patients). In adult patients with B-Cell ALL only FISH for ABL1/BCR and MLL are recommended.
☐ ETV/RUNX1(TEL/AML1) t(12;21)
☐ BCR/ABL1 PLUS t(9;22)
☐ CEP4/CEP10/CEP17
☐ MLL(KMT2A) 11q23 rearrangements
☐ P16(CDKN2A) del(9p)

☐ **T-Cell (T-ALL)**
☐ BCR/ABL1 PLUS t(9;22)
☐ MLL(KMT2A) 11q23 rearrangements
☐ P16 (CDKN2A) del(9p)
☐ TCRAD 14q11 rearrangements

☐ **Acute Myeloid leukemia (AML)**
*Please indicate subtype
☐ AML1/ETO (RUNX1T1/RUNX1) t(8;21) (M2)
☐ PML/RARα t(15;17) (M3)
☐ MLL(KMT2A) 11q23 rearrangements (M0-M7)
☐ CBFβ /MYH11 inv(16), t(16;16) (M4,Eos)
☐ EVI1(MECOM) inv(3), 3q26 rearrangements (M1,2,4,6,7)

☐ **Chronic Lymphocytic Leukemia (CLL)**
FISH panel is recommended in addition to chromosome analysis for this disorder.
☐ MYB/CEP6 del(6q)
☐ ATM/p53 del(11q)/del(17p)
☐ CEP 12 trisomy 12
☐ D13S319/13qter del(13q),-13
☐ CCND1/IGH t(11;14)
Reflex Only:
☐ IGH/BCL2 t(14;18)

☐ **Multiple Myeloma (MM) and Plasma Cell Proliferative Disorders (PCPD)**
FISH is recommended if bone marrow flow Cytometry shows ≥10% plasma cells, and should be offered in addition to chromosome analysis.
☐ IGH 14q32 rearrangements
☐ p53/ATM del(17p)
☐ D13S319/13qter del(13q),-13
☐ CEP9/CEP15
IGH Reflex Only:
☐ FGFR3/IGH t(4;14)
☐ CCND1/IGH t(11;14)
☐ IGH/MAF t(14;16)

☐ **Imatinib Mesylate (Gleevec) Responsive Genes (Myeloproliferative Neoplasms)**
☐ CHIC2 (PDGFRA) 4q12 rearrangements
☐ PDGFRB 5q33 rearrangements
☐ BCR/ABL1 PLUS t(9;22)
☐ FGFR1 8p12 rearrangements

☐ **Myelodysplastic Syndrome (MDS)**
FISH is recommended if chromosomes are not successful. Entire panel is suggested for patients with new diagnosis. 17p deletion (TP53) probe available upon request.
☐ 5q31 EGR1 deletion/-5 loss
☐ 7q31 del(7q)
☐ CEP7/CEP8
☐ 20q12 del(20q)
Reflex Only:
☐ MLL(KMT2A) 11q23 rearrangements
☐ EVI1(MECOM) inv(3), 3q26 rearrangements
☐ TEL/AML1 (ETV6/RUNX1) t(12;21)

☐ NHL **B-Cell Lymphoma (Blood or Bone Marrow and Tissue)**
☐ BCL6 3q27 rearrangements
☐ c-MYC 8q24 rearrangements
☐ IGH/BCL2 t(14;18)
Reflex Only:
☐ c-MYC/IGH t(8;14)
☐ CCND1/IGH t(11;14)
☐ MALT1 18q21 rearrangements
Tissue (Reflex) Only:
☐ CEP7/CEP12

☐ NHL **T-Cell Lymphoma (Blood or Bone Marrow and Tissue)**
☐ TCL1 14q32.1 rearrangements
☐ 7q31 del(7q)
☐ CEP7/CEP8
Tissue (Reflex) Only:

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☐ PBX1/TCF3 t(1;19) ☐ PDGFRB 5q32-33			☐ P16 (CDKN2A) del(9p) ☐ MLL(KMT2A) 11q23 rearrangement

FFPE FISH/ Soft Tissue/ Lymphoma/MISC FISH

☐ ***Large/Non-small cell Lung Cancer :*** ALK 2p23; ROS1 6q22; EGFR 7p11.2 ; C-MET 7q31; RET 10q11.2
☐ ***Brain Cancer:*** Oligodendroglioma 1p-/19q-
☐ ***Breast Cancer:*** HER2/neu (PathVysion) 17q11.2 -12
☐ ***Bladder Cancer:*** Urine bladder cancer (UroVysion)
☐ ***Prostate Cancer*:** PTEN 10q23.3
☐ ***Synovial Sarcoma*:** SYT (SS18) 18q11.2
☐ ***Ewing sarcoma*:** EWSR1 22q12
☐ ***Melanoma (Skin Cancer)* :** RREB1 6p25; CCND1 11q13; MYB/Cep6 6q23; cMYC 8q24, P16-CDKN2A 9p21(Spitzoid Only)
☐ ***Colorectal, Cervical, Endometrial, & Ovarian Cancer*:** C-MET 7q31; PTEN 10q23.3
☐ ***Gastric/Esophageal Tumor*:** Her2 17q11.2-12, C-MET 7q31, PTEN 10q23.3
☐ ***Thyroid Cancer*:** C-MET 7q31, PPAR Gamma 3p25.2, RET 10q11.2

Other
☐ CCND1/IGH t(11;14) ☐ BCL6 3q27 ☐ BCL2/IGH t(14;18) ☐ MALT1 18q21 ☐ MDM2 12q15 ☐ cMYC 8q24

7: PATIENT BILLING INFORMATION:

PLEASE INCLUDE A COPY OF THE INSURANCE CARD(S) FOR BILLING PUPPOSES.

□ **CLIENT BILL**	□ **INSURANCE**	□ **MEDICARE/MEDICAID**	□ **SELF PAY**

8: PATIENT AUTHORIZATION

I understand that I am responsible for providing accurate information about my insurance to Genesys Diagnostics Inc. I understand that Genesys Diagnostics Inc. will be providing testing service and billing my insurance. However, I understand that charges that are not covered by my insurance, including any applicable co-payments and deductibles are my responsibility and I agree to pay such charges promptly.

Signature of Patient/Responsible Party (REQUIRED) _____ Date (Required) _____

9: SPECIMEN COLLECTION INSTRUCTIONS:

Test	Specimen Type	Volume	Container	Storage Conditions	Special Instructions
Chromosome Analysis & FISH	Peripheral Blood	Adult/Child: 5-10 ml Newborn: 1-3 ml	**Sodium Heparin** **Green-top Tube**	Room Temperature	Do Not Freeze
	Bone Marrow	Adult/Child: 2-5 ml White cell count desired but not required	**Sodium Heparin** **Green-top Tube**	Room Temperature	Do Not Freeze
	Paraffin-embedded Tissue	**Positively Charged 4-5µ thick, 2 slides per probe minimum.** Fixation time between 6-48 hours.	Slide Mailer	Room Temperature	Include H&E Slide Mark Area of Interest
	Solid Tissue Biopsy	Sterile Saline/RPMI Media	Sterile Specimen Cup	Room Temperature or Refrigerate	Do Not Freeze **Do Not Add Formalin**
	Fine Needle Aspirate	Sterile Saline/RPMI Media	Sterile Centrifuge Tube with RPMI	Room Temperature	Do Not Freeze **Do Not Add Formalin**

10: SPECIMEN SHIPPING INSTRUCTIONS – FEDERAL EXPRESS SHIPPING INSTRUCTIONS

- Use sterile technique for specimen collection and close all containers tightly. **DO NOT FREEZE OR ADD FIXATIVE TO ANY SAMPLE.** Each specimen must be clearly labeled with at least two patient identifiers (patient's name and date of birth), along with the collection date. Secure each specimen container tightly to avoid leakage in transit.
- Complete the test requisition with the patient's demographics and insurance information. There is a secondary pouch in the biohazard bag for the test requisition. The clinical indication is required for appropriate cell culture parameters.
- Place the specimen in the absorbent material inside the enclosed biohazard bag. Then place the biohazard bag into the insulated specimen box labeled "Biohazardous Material" "Exempt Human Specimen". Please package the specimen carefully to protect it from breakage, leakage, and extreme temperatures. Place the specimen box inside the enclosed FedEx Clinical Pak (lab shipping bag) and seal.
- Attach the pre-labeled and prepaid FedEx air bill. You can call **FedEx at (800) 463-3339** to schedule a FedEx pickup. Alternately, a pick-up can be scheduled online at www.fedex.com . A two-hour notice may be required for same-day pick-up. Delivery address: **305 Flanders Rd. Unit 2, East Lyme Ct. 06333**, via FedEx overnight.
- Contact Laboratory for additional shipping materials, further instructions or any questions: **860-451-8046.**

Affix summary label here