Clear

University of Nebraska Medical Center
REGIONAL PATHOLOGY SERVICES

Regional Pathology Services
University of Nebraska Medical Center
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Omaha, Nebraska 68198-1180
www.reglab.org

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HEMATOPATHOLGY MOLECULAR ONCOLOGY TEST REQUEST FORM

Accession #: _____

Date Rec'd: ____/____/____ # of Slides: _____

SHADED AREAS FOR PATIENT INFORMATION REQUIRED

PATIENT LAST NAME | FIRST NAME | MI

DOB / / | GENDER ☐ MALE ☐ FEMALE | PT. ID# / ADDITIONAL INFO / MEDICAL RECORD NUMBER

SSN ___-___-___ | BILL ☐ OFFICE/CLIENT ☐ PATIENT/PATIENT INSURANCE

PATIENT INSURANCE
ATTACH COPY OF FRONT AND BACK OF INSURANCE CARD AND ATTACH COPY OF FRONT OF DRIVERS LICENSE IF UNABLE TO OBTAIN COPY OF REQUIRED INFORMATION ALL FIELDS BELOW ARE REQUIRED

GUARANTOR NAME/DOB (REQUIRED IF PATIENT IS A MINOR)

ADDRESS | CITY | STATE | ZIP

PRIMARY INSURANCE
☐ **MEDICARE IN-PATIENT** ☐ **MEDICARE OUT-PATIENT** ☐ **MEDICAID** ☐ **INSURANCE**

POLICY ID# | **GROUP ID#**

INSURANCE COMPANY | PHONE NUMBER

INSURANCE COMPANY ADDRESS | CITY | STATE | ZIP

EFFECTIVE DATE / /

DIAGNOSIS / MEDICAL NECESSITY (ENTER ALL THAT APPLIES)

ICD-10 #1 | ICD-10 #2 | ICD-10 #3

NOTICE: WHEN ORDERING TESTS FOR WHICH MEDICARE REIMBURSEMENT WILL BE SOUGHT, PHYSICIANS SHOULD ONLY ORDER TESTS THAT ARE MEDICALLY NECESSARY FOR THE DIAGNOSIS OR TREATMENT OF A PATIENT RATHER THAN FOR SCREENING PURPOSES. **FOR MORE INFORMATION SEE reglab.org/billingcompliance/**

Collection Date _____/_____/_____ **Collection Time** _____ **AM PM**

PHYSICIAN PROVIDER: _____
(Indicate the Supervising Dr./P.A. or N. Pract.)

PATHOLOGY CONSULTATION NUMBER

_____
Please provide direct phone number for pathology consultation if needed

_____
Account Number

_____
Account Name

_____
Address

_____
City, State & Zip Code

Phone Number: _____

Fax Number: _____

SECONDARY / TERTIARY INS – ATTACH INFORMATION

☐ ABN ATTACHED ☐ PRIOR AUTHORIZATION ATTACHED

HEMATOPATHOLOGY MOLECULAR ONCOLOGY TESTING

NOTICE: Additional reference laboratory testing may be required at the discretion of the pathologist to establish or confirm a diagnosis. If additional testing is needed the client or patient may receive an invoice for additional testing from the reference laboratory. ☐ **Check the box if additional reference laboratory testing is not desired.** Please note that a definitive diagnosis may not be possible.

CLINICAL INFORMATION

Attach all relevant clinical history, pathology/cytology report(s) and other applicable test reports.

SOURCE

☐ WHOLE BLOOD
☐ BONE MARROW ASPIRATE
☐ BONE MARROW CORE
☐ BONE MARROW PARTICLES/CLOT
☐ BLOCKS/SLIDES_____
☐ FLUID_____
☐ TISSUE_____
☐ OTHER_____

REASON FOR REFERAL

☐ New Diagnosis ☐ Relapse ☐ In Remission ☐ Monitoring
NOTE: _____

STAGING

☐ 0 ☐ II ☐ III ☐ IV
NOTE: _____

DIAGNOSTIC HISTORY/SUSPECTED DIAGNOSIS

Lymphoma
☐ Non-Hodgkin Lymphona ☐ Hodgkin Lymphoma ☐ Multiple Myeloma
☐ Unknown Type

Leukemia
☐ Acute Lymphoblastic Leukemia
☐ Acute Myelogenous Leukemia
☐ Hairy Cell Leukemia
☐ Myeloproliferative Disorder
☐ Chronic Lymphocytic Leukemia
☐ Chronic Myelogenous Leukemia
☐ Myelodysplastic Syndrome
☐ Unknown Type

Other Diagnosis
☐ Metastatic Tumor ☐ Aplastic Anemia ☐ Immunodeficiency
☐ Other:_____

RECENT TREATMENT HISTORY

☐ Chemotherapy ☐ Irradiation ☐ Antibody
☐ Growth Factor ☐ Autologous BMT/PSCT ☐ Allogeneic BMT/PSCT
Other: _____
Date of BMT/PSCT:_____
Type and Date of Last Treatment:_____

CONSULTATION

A pathologist will select medically necessary tests (with any exceptions marked by the client) to provide comprehensive analysis and professional interpretation for the materials submitted. Please attach CBC (required).

☐ Slide Consultation
Case Number_____
Slide(s)/Block(s) Sent_____
☐ Bone Marrow Evaluation
☐ Lymph Node/Tissue Evaluation

CYTOGENETICS

☐ Conventional Cytogenetics
☐ FISH Cytogenetics (specify) _____
_____

FLOW CYTOMETRY STUDIES

☐ Flow Cytometry Initial Diagnostic Evaluation*
☐ Flow Cytometry Remission Assessment*
***Include recent CBC and differential**

LYMPHOMA

☐ T Cell Gene Rearrangement
☐ B Cell Gene Rearrangement
☐ Heme Mutation TP53 (L)
☐ MYD88 (L)
☐ DLBCL (L) Expression analysis (GBC vs ABC)

ACUTE MYELOGENOUS LEUKEMIA

☐ FLT3
☐ NPM1
☐ PML-RARA
☐ IDH1
☐ IDH2
☐ IDH1 and IDH2 Mutation Analysis
☐ PML-RARA Rearrangement
☐ KIT (p.D816V) mutation in systemic mastocytosis
☐ JAK2 Mutation Order by Next Generation Sequencing (NGS)

MOLECULAR STUDIES

☐ BCR/ABL1 Translocation, Qualitative (p210 & p190, for diagnosis)
☐ BCR/ABL1 Translocation, Quantitative (p210 only, for therapy monitoring)
☐ BRAF Mutation (p.V600E)
☐ FLT3 Mutation (Internal Tandem Duplication)
☐ NPM1 Mutation
☐ IDH1 and IDH2 Mutation
☐ PML/RARA translocation by RT-PCR (non-quantitative, for Minimal Residual Disease)
☐ IgH Heavy Chain Gene Rearrangement
☐ JAK2 (p.V617F) Mutation
☐ CALR mutation
☐ MPL mutation
☐ KIT p.D816 mutation (for Systemic Mastocytosis)
☐ T-Cell Receptor Gamma Chain Gene Rearrangement

MYELOPROLIFERATIVE NEOPLASMS

☐ BCR-ABL 1 Qualitative
☐ BCR-ABL 1 Quantitative
☐ CALR Exon 9
☐ JAK2 (p.V617F)
☐ JAK2 Exon 12
☐ JAK2 Exon 14 reflex to Exon 12
☐ MPL Codons 505 and 515
☐ KIT (p.D816V) mutation in systemic mastocytosis
☐ Myeloproliferative Neoplasm (MPN)
JAK2 (Exons 12, 13, 14, 15, hotspots), MPL (Exons 3,4,10,12 hotspots), CALR (full gene), KIT (Exons 1,2,8-11,13,17 hotspots), CSF3R (Exons 14,17,18 hotspots)
☐ Blood
☐ Bone Marrow
☐ Myeloid Panel
Hotspot genes (23) ABL1, BRAF, CBL, CSF3R, DNMT3A, FLT3, GATA2, HRAS, IDH1, IDH2, JAK2, KIT, KRAS, MPL, MYD88, NPM1, NRAS, PTPN11, SETBP1, SF3B1, SRSF2, U2AF1, WT-1Full Genes (17)ASXL1, BCOR, CALR, CEBPA, ETV6, EZH2, IKZF1, NF1, PHF6, PRPF8, RB1, RUNX1, SH2B3, STAG2, TET2, TP53, ZRSR2
☐ Blood
☐ Bone Marrow

FOR DETAILED TESTING INFORMATION VISIT REGLAB.ORG

Testing Supplies

Regional Pathology Services furnishes specimen-collection supplies for use by clients that send tests to us.

Supplies are ordered online at reglab.org/customer-service/supply-orders/ testing supplies and log-on information may be obtained by calling Client Services
Toll Free 800-334-0459
Phone 402-559-6420

Courier Services

Regional Pathology Services offers an extensive courier network, which includes contracted land and air courier services. Contracted land specimen pickup is provided at no charge for specimens tested by Regional Pathology Services or our designated reference laboratories.

To inquire about scheduled stops and after hours courier service, call
Client Services Toll Free 800-334-0459
Phone 402-559-6420

If shipping specimens address to:
UNMC Shipping & Receiving Dock
Regional Pathology Services MSB 3500
University of Nebraska Medical Center
601 Saddle Creek Road
Omaha, NE 68106-1180

Transport Instructions:
Specimen Handling/Shipping
To ensure the safety of personnel and the community, proper handling of specimens for shipment is mandatory. Specimens will be rejected if submitted improperly. The shipper is responsible for the proper packaging and shipping of all specimens. Shippers must be trained and certified by their employer to be able to prepare and ship packages containing diagnostic specimens, biological substances and infectious substances. Rules of the various agencies involved may differ, and may change regularly. Specimen must have at least two patient identifiers and be packaged in sealed plastic bags to prevent leakage or contamination. Place accompanying paperwork in the bag pocket, away from the specimen. Practice universal blood and body fluid precautions when handling specimens.

For tests that require scheduling or special arrangements prior to specimen collection, refer to the Online Test Menu at reglab.org for more information.

Questions?
Contact client services at 800-334-0459