

ONCOLOGY Test Request Form

PAGE 1 / 2

A. PATIENT IDENTIFICATION

NAME: _____ DOB: _____ MR#: _____ FEMALE
 MALE
 PHONE#: _____ ADDRESS: _____ CITY/ST/ZIP: _____

B. SPECIMEN / CLINICAL INFORMATION

Access specimen requirements at: www.unmc.edu/geneticslab

- Send specimens immediately - avoid extreme temperatures. Testing is most successful when performed on samples received within 24 hours of collection.
- If immediate shipment is not possible, contact us and store at room temperature (urine/bladder washings should be refrigerated).

COLLECTION DATE: _____ COLLECTION TIME: _____

SPECIMEN ID (e.g., Surgical Path #): _____

INDICATIONS FOR TESTING: _____

Diagnostic Follow Up

PRIOR TREATMENT? No | Yes radiation chemotherapeutic

BONE MARROW/TISSUE TRANSPLANT? No | Yes same sex opposite sex

PATIENT CONSENT: Check this box if your patient does not wish to have their specimen stored. Consent is implied if box is left unchecked.

Bone Marrow | Bone Marrow Core

Blood (Leukemic/Cancer)

Lymphatic Tissue/Node | Solid Tumor

» Anatomical Site **MUST** be described:

» _____

Paraffin Embedded Tissue

Are there specific areas of interest for FISH analysis?

No | Yes » send corresponding H&E with area(s) indicated

Urine/Bladder Washings

Other - [specify]: _____

C. TEST SELECTION

Chromosome Analysis

▼ **FISH Analysis** (select panel(s) and/or probe(s) below) - Note: FISH assessment of previously identified abnormalities as well as an indication-related probe panel may be of clinical utility in follow-up cases; please select the designated panel below when appropriate

Previous Abnormalities

Order code format for RPS staff: (Culture or fresh / Direct or FFPE)

Indication-specific FISH Panels (see website for full test/probe details)

- ALL-Pediatric (FALLP/FDALP)
- ALL-Adult (FALLA/FDALL)
- ALL-Ph-like (FINT/FDIR)
- ALL-T-cell (FTCEL/FDIR)
- CML (FCML/FDCML)
- Eosinophilia (FEOSN/FDIR)

- AML (FAML/FDIR)
- MDS (FMDS/FDMPS)
- MPN (FMPD/FDMPD)
- MDS/MPN (FMDSM/FDMMP)
- CLL/SLL (FCLL/FDCLL)

- Burkitt lymphoma (FINT/FDIR)
- Follicular lymphoma (FINT/FDIR)
- Mantle cell lymphoma (FINT/FDIR)
- Marginal zone lymphoma (FMARG/FDMAR)
- High-grade lymphoma/DLBCL/NHL (FNHL/FDNHL)
- Plasma cell dyscrasia/multiple myeloma (FMM/FDMM)

Individual FISH Probes (multiple probes can be chosen) (FINT/FDIR)

- 6q21 / 6q23
- 15q22
- 20q12
- ABL1 [9q34]
- ABL2 [1q25.2]
- ALK [2p23]
- ATM [11q22.3]
- BCL2 [18q21]
- BCL6 [3q27]
- BCR / ABL1 [t(9;22)] / LSI 9q34
- BIRC3 (API2) / MALT1 [t(11;18)]
- CBF3 [16q22]
- CCND1 [11q13]
- CCND2 [12p13]
- CCND3 [6p21.1]
- CDKN2A (P16) [9p21]
- CDKN2C (1p32.3) / CKS1B (1q21.3)
- CRLF2 [Xp22.33/Yp11.3]
- D13S319 [13q14] / 13q34
- D7S486 [7q31] / 7 centromere
- DEK/NUP214 [t(6;9)]
- EGR1 [5q31]

- EPOR [19p13.2]
- ETV6 (TEL) [12p13]
- ETV6 / RUNX1 (TEL / AML1) [t(12;21)]
- FGFR1 [8p12]
- FIP1L1 / CHIC2 / PDGFRA [4q12]
- IGH [14q32 abnormalities]
- IGH / BCL2 [t(14;18)]
- IGH / CCND1 [t(11;14)]
- IGH / FGFR3 [t(4;14)]
- IGH / MAF [t(14;16)]
- IGH / MAFB [t(14;20)]
- IGH / MALT1 [t(14;18)]
- IGH / MYC / 8 centromere [t(8;14)]
- IGK [2p11.2]
- IGL [22q11]
- IRF4 / DUSP22 [6p25.3]
- JAK2 [9p24]
- KAT6A/CREBBP [t(8;16)]
- KMT2A (MLL) [11q23]
- MALT1 [18q21] / 18 centromere
- MECOM (EVI1) [3q26.2]
- MLLT10 (AF10) [10p12]

- MLLT10 (AF10) / PICALM [t(10;11)]
- MYC [8q24]
- P2RY8 [Xp22.3/Yp11.3]
- PBX1 / TCF3 [t(1;19)]
- PDGFRB / CSF1R [5q32]
- PML / RARA [t(15;17)]
- RARA [17q21]
- RUNX1T1 / RUNX1 (ETO / AML1) [t(8;21)]
- TCL1A [14q32]
- TP53 [17p13.1]
- TRA/D (TCR) [14q11.2]
- TRB (TCRB) [7q34]
- Other: _____

Microarray Analysis

CONTINUE TO PAGE 2 ►

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 MALE

D. BILLING ▪ Contact our billing team for insurance preauthorization assistance at 402.559.8359

1) Does this patient live in a skilled nursing facility? Yes No 2) Has the patient been inpatient in the last week? Yes No

INSURANCE BILLING » *Include a clear, enlarged copy of both sides of the insurance card*

- **ICD-10 CODE(S):** _____
 - Patient Insurance | Policy holder is different than patient
 » Policy Holder Name: _____ DOB: _____
 - Medicaid | Medicaid Pending | Medicare » *An ABN may be required*
- **Verify coverage for genetic testing and obtain/request preauthorization when required**
 - Preauthorization approved
 » Auth#: _____ Valid Date: _____ Exp Date: _____
 - Preauthorization service requested
 » *Contact RPS Billing Support at rpsbillingsupport@unmc.edu*

CLIENT BILLING

Facility: _____
Address: _____
City/St/Zip: _____
Phone: _____ Fax: _____

PATIENT SELF-PAY
» *View patient billing options at:*
<http://www.reglab.org/billingcompliance/participating-insurance-plans/>

E. RESULT REPORTING

ORDERING LOCATION:
Facility: _____
Client Code: _____
Address: _____
City/State/Zip: _____
Phone: _____ Fax: _____
Email: _____

ORDERING PROVIDER:
Name: _____
Delivery Method: _____

ADDITIONAL REPORT(S) TO:
Name: _____ Name: _____
Delivery Method: _____ Delivery Method: _____

F. SHIPPING

Shipping supplies including collection kits, tubes, transport media, and prepaid airbills are available through our supply portal.
Local Transport: Call the laboratory (402-559-6420) to request specimen pickup or utilize your routine RPS courier.
Shipping Address: UNMC Shipping & Receiving Dock
Regional Pathology Services MSB 3500
University of Nebraska Medical Center
601 Saddle Creek Road
Omaha, NE 68108-1180