Clear Form

University of Nebraska Medical Center
REGIONAL PATHOLOGY SERVICES

Regional Pathology Services
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SOLID TUMOR Test Request Form

A. PATIENT IDENTIFICATION

PATIENT LABEL
including:
- name
- DOB
- gender
- surgical path #

B. TEST SELECTION

☐ **CHROMOSOME ANALYSIS**

FISH ANALYSIS:

☐ **1p36 deletion**
☐ **1p36/1q25**
☐ **19q13/19p13**
☐ **ALK** [2p23]
☐ **CDK4** [12q13.14]
☐ **CDKN2A (P16)** [9p21]
☐ **COL1A1/PDGFB** [t(17;22)]
☐ **DDIT3 (CHOP)** [12q13]
☐ **EGFR** [7p12]
☐ **ETV6 (TEL)** [12p13]
☐ **EWSR1** [22q12]
☐ **EWSR1/ATF1** [t(12;22)]
☐ **EWSR1/CREB1** [t(2;22)]
☐ **EWSR1/WT1** [t(11;22)]
☐ **FOXO1** [13q14]
☐ **FUS** [16p11.2]
☐ **FUS/CREB3L2** [t(7;16)]
☐ **HER2 [17q11.2-12]**
☐ **HMGA2 [12q14.3]**
☐ **MDM2** [12q15]
☐ **MYC [8q24]/8 centromere**
☐ **MYCN** [2p24.1]
☐ **NUTM1** [15q14]
☐ **NUTM1/BRD4** [t(15;19)]
☐ **PAX3** [2q36]
☐ **PLAG1** [8q12.1]
☐ **PTEN** [10q23]
☐ **RB1** [13q14]
☐ **RET** [10q11]
☐ **ROS1** [6q22]
☐ **SMARCB1 (INI1)** [22q11.23]
☐ **SS18 (SYT)** [18q21/t(X;18)]
☐ **TFE3** [Xp11]
☐ **Urovysion**
3/7/17 centromere
CDKN2A (P16) [9p21]
☐ **USP6** [17p13]
☐ **other:**

☐ **any FISH necessary to clarify diagnosis**

☐ **MICROARRAY ANALYSIS**

SPECIAL INSTRUCTIONS / NOTES:

C. CLINICAL INFORMATION

Please include all likely diagnoses in the differential.

DIAGNOSIS / INDICATION:

D. SPECIMEN INFORMATION

COLLECTION DATE: _____ **COLLECTION TIME:** _____

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

TISSUE TYPE: _____

ANATOMICAL SITE: _____

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

☐ **Paraffin Embedded Tissue**
- ▶ **Array:** » *5-10 dissected cores from selected malignant region*
- ▶ **FISH:** » *2-3 slides per probe (4-5 micron sections)*
  - Are there specific areas of interest for FISH analysis?
    ☐ **Yes** » *send corresponding H&E with area(s) indicated* ☐ **No**

☐ **Solid Tumor** » *5mm^3 in tissue culture media*

☐ **Urine / Bladder Washings** » *30ml in sterile container*

E. BILLING

☐ **RPS** ☐ **Nebraska Medicine**

F. RESULT REPORTING

ORDERING LOCATION:
Facility: _____
Client Code: _____ (HGL) _____ (RPS)
Address: _____
City/State/Zip: _____
Phone: _____ Fax: _____
Email: _____
ORDERING PROVIDER:
Name: _____
Delivery Method: _____

G. TESTING LABORATORY

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END OF FORM ■