THE UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER

# Genetics Laboratory Department of Pediatrics
# Genetics Requisition For Hematology/Oncology

O'Donoghue Research Bldg
1122 NE 13 Street, Suite 1400
Oklahoma City, OK 73104
Phone: 405-271-3589
Fax: 405-271-7117
After hours phone: 405-496-9514
www.genetics.ouhsc.edu

Patient Sticker Here



## REFERRING PHYSICIAN/FACILITY/CLINICAL INFO

Physician Name_____

Phone(____)_____ Fax (___)_____

Clinic/ Hospital_____

Phone(____)_____ Fax (___)_____

Reason for Study_____

Date Specimen Collected_____ **WBC**_____

## PATIENT AND BILLING INFORMATION

Patient Name (last,first,m.)_____

Parent Name (if patient is a minor)_____

DOB_____ SSN_____ MRN_____

**Sex:** □ Male □ Female □ Ambiguous □ Unknown □ Inpatient □ Outpatient

Ethnicity of patient (check all that apply)
□ African-American □ Asian □Caucasian/NW European □ E. Indian
□ Hispanic □ Jewish-Ashkenazi □ Jewish-Sephardic □ Native American
□ Native Hawaiian/Other Pacific Islander □ Other_____

Patient's Address_____

City_____ State_____ Zip Code_____

## SPECIMEN TYPES for Chromosome and/or FISH Analysis ( See Page 2 for Collection Requirements)

☐ **Bone Marrow** ☐ **Leukemic Blood/Peripheral Blood for neoplastic study** ☐ **Solid Tumor** ☐ **Unstained Slides (FISH testing only)**

## Chromosome and/or FISH Analysis

□ **Karyotype** (routine chromosome analysis) □ **Karyotype and FISH** Select a FISH probe below □ **FISH only** Select a FISH probe below

**Acute Myeloid Leukemia (AML) panel**
□ t(8;21)(q22;q22) ETO/AML
□ t(15;17)(q24;q21.2) PML/RARA
□ inv(16)(913q22)/ t(16;16) CBFB/MYH11
□trisomy 8 cen8/c-MYC
□ 11q23 rearrangement KMT2A
□ t(9;11)(p21;q23) KMT2A/MLLT3
□ t(6;11)(q27;q23) KMT2A/AFDN
□ t(11;19)(q23;p13.3) KMT2A/MLLT1
□ t(6;9)(p22;q34) DEK/NUP214
□ -5/5q- EGR1/D5S721
□ -7/7q- CEP7/D7S486

**B-cell Acute Lymphoblastic Leukemia (ALL) panel**
□ t(12;21)(p13;q11.2) TEL/AML1
□ t(9;22)(q34;q11.2) BCR/ABL1
□ t(1;19)(q23;p13.2) TCF3/PBX1
□ del(9p21) CDKN2A/CEP9
□ t4/t10 CEP4/CEP10
□ 11q23 rearrangement KMT2A
□ t(4;11)(q21;q23) KMT2A/AFF1
□ t(11;19)(q23;p13.3) KMT2A/MLLT1

**T-cell Acute Lymphoblastic Leukemia (T-ALL)**
□ t(9;22)(q34;q11.2) BCR/ABL1
□ 11q23 rearrangement KMT2A
□ inv(14)(q11q32.1)/(14;14)(q11;q32.1) TRA-TRD/TCL1A
□ inv(7)(p15;q34)/t(7;7)(p15;q34)TRB/HOXA10
□ Xq28 rearrangement MTCP1/T-PLL

**Chronic Lymphocytic Leukemia (CLL) panel**
□ del(6q23) MYB
□ del(11q22.3) ATM/CEP11
□ trisomy 12
□ del(13q14.3) D13S319/LSI13q34
□ del(17p13) TP53/CEP17
□ t(11;14)(q13;q32) CCND1/IGHG1
□ t(14;18)(q32;q21) IGHG1/BCL2

**Chronic Myelogenous Leukemia (CML)**
□ t(9;22)(q34;q11.2) BCR/ABL1

**Lymphoma panel**
□ 8q24 rearrangement MYC
□ t(8;l4)(q24;q32) IGHG1/MYC
□ t(11;14)(q13;q32) IGHG1/CCND1
□ t(14;18)(q32;q21) IGHG1/BCL2
□ t(14;18)(q32;q21)IGHG1/MALT1
□ 3q27 rearrangement BCL6
□ 18q21 rearrangement MALT1
□ 18q21 rearrangement BCL2
□ t(11;18)(q21;q21) BIRC3/MALT1
□ 2p23 rearrangement ALK

**Eosinophilia panel**
□ 4q12 rearrangement FIP1L1/PDGFRA
□ 5q33 rearrangement PDGFRB
□ 8p11 rearrangement FGFR1
□ inv(16)(p13;q22)/t(16;16)(p13;q22) CBFB

**Myeloproliferative Neoplasms panel**
□ t(9;22)(q34;q11.2) BCR/ABL1
□ 4q12 rearrangement FIPIL1/PDGFRA
□ 5q33 rearrangement PDGFRB
□ 8p11 rearrangement FGFR1

**Myelodysplastic syndrome (MDS) panel**
□ -5/5q- EGR1/D5S721
□ -7/7q- CEP7/D7S486
□ trisomy 8
□ del(13q14.3) D13S319/LSI13q34
□ del(20q) D20S108
□ 3q26 rearrangement MECOM

**Genetics Lab Use Only**
Lab No._____Date Recvd_____
Checked in by_____ Location_____

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Patient Name Last_____ First_____ MI_____

## Chromosome and/or FISH Analysis

☐ **Karyotype** (routine chromosome analysis) ☐ **Karyotype and FISH** (Select a FISH probe below) ☐ **FISH only** (Select a FISH probe below)

**Multiple Myeloma (MM) panel**
- ☐ 14q32 rearrangement IGHG1
- ☐ t(14;16)(q32;q23) IGHG1/MAF
- ☐ t(4;14)(p16;q32) IGHG1/FGFR3
- ☐ t(11;14)(q13;q32) IGHG1/CCND1
- ☐ del(17p13) TP53/CEP17
- ☐ del(13q14.2) RB1 LSI13q14/LSI13q34
- ☐ trisomy 9/trisomy 15
- ☐ trisomy 3/trisomy 7
- ☐ dup(1q21) CHD5/S100A10
- ☐ t(14;20)(q32;q12) IGHG1/MAFB
- ☐ t(6;14)(p21;q32) IGHG1/CCND3

**Other Malignancies**
- ☐ n-MYC 2p24 amplification in neuroblastoma
- ☐ t(5;12) PDGFRB/TEL
- ☐ 12q15 MDM2 differentiated liposarcoma
- ☐ 6q23 rearrangement MYB
- ☐ 12p13 rearrangement ETV6
- ☐ 8q24 rearrangement c-MYC
- ☐ 17p13 deletion TP53
- ☐ 18q21 rearrangement BCL2
- ☐ 4q12 rearrangement FIP1L1
- ☐ 13q14 rearrangement FOXO1
- ☐ 11q13 rearrangement CCND1
- ☐ 5q33-q34 deletion CSF1R
- ☐ 2p23 rearrangement **ALK**
- ☐ t(17;22)(q21;q13) COL1A1/PDGFB
- ☐ t(15;19)(q14;p13) BRD4/NUTM1
- ☐ 9q34 rearrangement BRD3
- ☐ 8q12 rearrangement PLAG1
- ☐ Xp11.2 rearrangement TFE3
- ☐ 1q23.1 rearrangement PRCC
- ☐ 17q25.2 rearrangement ASPSCR1
- ☐ 7q34 rearrangement BRAF
- ☐ 9q31.1 rearrangement NR4A3
- ☐ MYCN gene amplification neuroblastoma/medulloblastoma
- ☐ 16p11.2 FUS myxoid/round cell liposarcoma
- ☐ 12q13 CHOP myxoid/round cell liposarcoma
- ☐ 18q11.2 SS18 synovial sarcoma
- ☐ 6q22 rearrangement **ROS1**
- ☐ 7p12 amplification EGRF
- ☐ 13q14 FKHR rhadomyosarcoma
- ☐ 1p/del(19q) oligodendrogliomas
- ☐ 13q14 deletion RB1
- ☐ TRA/D 14q11.2
- ☐ 22q12 Ewing sarcoma EWSR1
- ☐ 6p21.1 rearrangement TFEB
- ☐ 11p13 rearrangement WT1
- ☐ 11q21 rearrangement MAML2
- ☐ 6p21.3 rearrangement PHF1
- ☐ 17p13 rearrangement YWHAE/USP6
- ☐ 7p15.1 rearrangement JAZF1
- ☐ 15q25.3 rearrangement NTRK3
- ☐ 15q22.2 rearrangement TCF12
- ☐ 15q22.2 rearrangement TAF15

### Specimen Requirements for Chromosome and/or FISH analysis

**Bone Marrow**
Place in heparinized syringe, large sodium heparin tube (dark green top) or transport medium.
Fresh sample keep at room temperature, do not freeze. No additional specimen is needed for FISH studies.

**Leukemic Blood/Peripheral Blood for neoplastic study**
3-5 cc in large sodium heparin tube (dark green top). Fresh sample keep at room temperature, do not freeze. No additional specimen is needed for FISH studies.

**Solid Tumor** 2-3 cc/1-2cm2 in transport media or sterile normal saline. Do not use formalin and do not use a fixative. Observe sterile technique. Keep cool, do not freeze.

**Unstained Slides** we request 2 slides for each FISH probe ordered. Please circle the area on the slide you would like analyzed.

**Genetics Lab Use Only**
Lab No._____Date Recvd_____
Checked in by_____ Location_____

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**Genetics Laboratory**
**Billing Information Form**

Patient Name LAST_____ FIRST_____ MI_____

**YOU MUST CHOOSE ONE OF THE THREE BILLING OPTIONS LISTED BELOW.**
**PLEASE FORWARD ALL BILLING QUESTIONS TO DANIELLE OTIS AT DOTIS@OUHSC.EDU OR CALL 405-271-3589 OPT 4**
**AT THIS TIME WE DO NOT ACCEPT OUT-OF-STATE MEDICAID**

**PAYMENT OPTION 1-INSTITUTION**

INSTITUTION NAME _____

BILLING ADDRESS_____

CITY, STATE, ZIP _____ CONTACT NAME_____

PHONE NUMBER_____ FAX NUMBER_____ CONTACT EMAIL ADDRESS _____

**PAYMENT OPTION 2-SELF PAY (PAYMENT MUST BE SENT WITH SAMPLE)**

☐ **CREDIT CARD** (CIRCLE ONE) AMEX DISCOVER VISA MASTERCARD AMOUNT TO CHARGE_____

VALID CARD # _____ EXP DATE_____

CVV CODE _____ CARDHOLDER PRINTED NAME_____

BILLING ADDRESS _____ CITY, STATE, ZIP_____

CARDHOLDER SIGNATURE _____

☐ **CHECK #** _____ AMOUNT ENCLOSED_____

**PAYMENT OPTION 3-INSURANCE PROVIDE A LEGIBLE COPY OF THE FRONT & BACK OF INSURANCE CARD**
**PLEASE NOTE: OUR FACILITY WILL CONFIRM COVERAGE AND VERIFY WHETHER OR NOT THE TEST(S) ORDERED ARE COVERED BY YOUR PLAN.**
**OUR OFFICE CAN ALSO OBTAIN PRE-AUTHORIZATION FROM THE INSURANCE PLAN.**

**PRIMARY** INSURANCE POLICYHOLDER NAME _____ POLICYHOLDER DOB_____

PRIMARY POLICYHOLDER SS# _____ GENDER: ○ M ○ F EMPLOYER_____

RELATIONSHIP TO PATIENT_____ POLICY # _____

GROUP #_____ INSURANCE CO. NAME _____

PHONE _____ CLAIMS ADDRESS _____

CITY, STATE, ZIP_____ INSURANCE AUTH #_____

**SECONDARY** INSURANCE POLICYHOLDER NAME _____ POLICYHOLDER DOB_____

SECONDARY POLICYHOLDER SS# _____ GENDER: ○ M ⊙ F EMPLOYER_____

RELATIONSHIP TO PATIENT_____ POLICY # _____

GROUP #_____ INSURANCE CO. NAME _____

PHONE _____ CLAIMS ADDRESS _____

CITY, STATE, ZIP_____ INSURANCE AUTH #_____

I CONSENT TO HAVE THE TEST(S) LISTED ON THE PREVIOUS PAGE PERFORMED. I AUTHORIZE THE UNIVERSITY OF OKLAHOMA HSC GENETICS LABORATORY TO FURNISH ANY MEDICAL INFORMATION REQUESTED ON MYSELF, OR MY COVERED DEPENDENTS. IN CONSIDERATION OF SERVICES RENDERED, I TRANSFER AND ASSIGN ANY BENEFITS OF INSURANCE TO UNIVERSITY OF OKLAHOMA HSC GENETICS LABORATORY. I UNDERSTAND I AM RESPONSIBLE FOR ANY CO-PAY, DEDUCTIBLES, OR NON-AUTHORIZED SERVICES AND REMAINING BALANCES AFTER INSURANCE REIMBURSEMENT. I UNDERSTAND I AM FULLY RESPONSIBLE FOR PAYMENT OF MY ACCOUNT IF THE UNIVERSITY OF OKLAHOMA HSC GENETICS LABORATORY IS NOT A PARTICIPANT WITH MY HEALTH PLAN OR MY HEALTH PLAN DOES NOT FULLY REIMBURSE MY MEDICAL SERVICES DUE TO LACK OF AUTHORIZATION OR MEDICAL NECESSITY.

PRINTED NAME _____ SIGNATURE_____ DATE _____