# CANCER TEST REQUISITION FORM

**Cytogenetic Laboratories**
Indiana University School of Medicine
975 W. Walnut, IB 350, Indianapolis, IN 46202
**317/274-2243 (Office) 317/278-1616 (Fax)**

*Patient Laboratory Label*

**CAP#: 16789-30 CLIA#: 15D0647198**

## 1) PHYSICIAN(S):

Referring Physician:_____
Address:_____
City: _____State: ____ Zip: _____
Phone:_____ Fax:_____

Primary Physician:_____
Phone:_____ Fax:_____

## *FOR LABORATORY USE ONLY:*

Date Received: ____/____/____ Family #: _____
Time Received: _____:_____am/pm Proband: ☐
Received By _____ Not Proband: ☐

BM/DN: ☐ BM/RN: ☐ BM/DA: ☐ BM/RA: ☐ ST: ☐
FISH: ☐ x _____ Probes FISH ONLY: ☐
Handling Charge: ☐ x _____ Handling ONLY: ☐
Lab Comment(s): Vacs: _____ green _____ purple; Other: _____

## 2) PATIENT INFORMATION:

Patient Name:_____
*Last Name* *First Name* *Middle Initial*
Address:_____
Street *City* *State* *Zip Code*
Hospital:_____ Medical Record #:_____

Date of Birth: ____/____/____ Sex: ☐ Male ☐ Female **If Post-Transplant, Donor Sex:** ☐ Male ☐ Female ☐ Autologous
*Month Day Year*
WBC ($X10^3$):_____ Blasts: _____

## 3) CLINICAL INFORMATION (*DO NOT FREEZE SPECIMENS – ALL SPECIMENS MUST BE LABELED):*

Collection Date: ____/____/____ Collection Time:_____am/pm Collected By: _____
*Month Day Year*
**Referring Diagnosis**:_____

## 4) SPECIMEN INFORMATION and REQUESTED TESTING:

☐ Bone Marrow (***ROOM TEMP***)
☐ Bone Core (***ROOM TEMP***)
☐ Peripheral Blood for Leukemic Studies (***ROOM TEMP***)
☐ Tumor / Type: _____ Site: _____
☐ Biliary Stricture
☐ Urine (Bladder Cancer)

**REQUESTED TESTING**
☐ Standard Chromosome Analysis (Karyotype) *ONLY*
☐ Chromosome Analysis & Fluorescence In Situ *(Select Probe/Panel below)*
☐ Fluorescence In Situ (FISH) Analysis *ONLY*
☐ Fluorescence In Situ STAT analysis **(t(15;17) PML/RARA probe *ONLY*)**

**FISH Panels – Cancer/Oncology:**

☐ **FISH ALL Panel – Pediatric (≤18)**: CRLF2, t(1;19), ABL2, 4/10/17cen, PDGFRB, 9p21, ABL1, t(9;22), KMT2A, t(12;21)

☐ **FISH ALL Panel – Adult (>18) with Ph-like Reflex**: CRLF2, t(1;19), 4/10/17cen, 9p21, t(9;22), KMT2A, t(12;21); reflex for t(9;22) neg includes ABL2, PDGFRB, ABL1

☐ **FISH CLL Panel** del(6q), t(11;14), ATM, 12cen, 13q, TP53

☐ **FISH MDS Panel**: -5/del(5q), del(7q), 8cen, 11q23 (KMT2A), del(20q) **All in AML Panel*

☐ **FISH MPN Panel**: -5/del(5q), del(7q), 8cen, t(9;22), 9q34, del(20q)

☐ **FISH AML Panel**: inv(3), -5/del(5q), t(6;9), del(7q), 8cen, t(8;21), KMT2A, t(15;17), t(16;16), del(20q)
**t(15;17) Stat?☐ Yes☐ No**

☐ **FISH Lymphoma Panel**: BCL6, MYC, t(14;18), reflex t(8;14) if MYC abnormal

☐ **FISH Plasma Cell Myeloma Panel with Reflex**: 1q21, 5p, 5q, 7q, t(11;14), 13q14.2 (RB1)/13q14.3 (D13S319), IGH, 17p13.1 (TP53); reflex if IGH rearranged to t(4;14) FGFR3::IGH and t(14;16) IGH::MAF

**UROVYSION**
☐ **FISH UroVysion Panel** (Biliary brushing)
☐ **FISH UroVysion Panel** (Urine)

**FISH PET – Cancer/Oncology:**
☐FISH-HER2 Breast Cancer
☐FISH-HER2 Gastroesophageal Cancer
☐FISH-HER2 Non-Breast Tissue

☐ FISH-PET Lymphoma Panel: BCL6, MYC, t(14;18), reflex t(8;14) if MYC abnormal

**Individual PET probes (each probe reported separately)**
☐ FISH-3q27 (BCL6)
☐ FISH t(8;14) MYC:IGH
☐ FISH 8q24 (MYC)
☐ FISH-t(14;18) IGH::BCL2

**FISH Individual Probes – Cancer/Oncology**

☐1q21,8p
☐t(1;19) PBX1::TCF3
☐1q25.2 (ABL2)
☐2p23.2 (ALK)
☐2p24.1 (MYCN)
☐3q27 (BCL6)
☐inv(3) RPN1::MECOM
☐4q12 (PDGFRA,CHIC2)
☐t(4;14) FGFR3::IGH
☐5q33.2 (PDGFRB)
☐-5/del(5q)
☐t(6;9) DEK::NUP214
☐del(6q)
☐del(7q)
☐8 Centromere,del(20q)
☐8q24 (MYC)
☐t(8;14) MYC::IGH
☐t(8;21) RUNX1T1::RUNX1
☐9p21 (CDKN2A)
☐9q34.1 (ABL1)
☐t(9;22) BCR::ABL1
☐9q34 (ASS1)
☐t(11;14) CCND1::IGH
☐t(11;18) BIRC3::MALT1
☐11p15.4 (NUP98)
☐11q23 (KMT2A)
☐12 Centromere
☐12p13 (ETV6)
☐t(12;21) ETV6::RUNX1
☐13q14 (FOXO1)
☐13q14 (RB1,D13S319)
☐14q32.3 (IGH)
☐t(14;16) IGH::MAF
☐t(14;18) IGH::BCL2
☐t(15;17) PML::RARA
☐t(16;16) CBFB::MYH11
☐17p13.1 (TP53)
☐17q21.1 (RARA)
☐del(20q),8 Centromere
☐22q12 (EWSR1)
☐X/Y
☐Xp22.3/Yp11.2 (CRLF2)

## 5) SPECIMEN SHIPPING/HANDLING INFORMATION

| Specimen | Collection | Container(s) | Instructions |
|---|---|---|---|
| Peripheral Blood for cancer analysis | 7-10mL whole blood (adults)<br>2-4mL whole blood (infants) | Dark Green-top sodium heparin tube. | **Keep at room temperature.** |
| Bone Marrow Aspirate | **0.5 mL minimum**<br>2 mL preferred for normal WBC<br>↓ WBC requires more<br>↑ WBC requires less<br>1-2 mL preferred | Dark Green-top sodium heparin tube. | **Keep at room temperature.** |
| Formalin-fixed, Paraffin-Embedded Tissue (PET) | 4-micron sections on positively charged, circled/marked slides (2-3 slides are sufficient)<br>Corresponding H&E section with area of tumor marked.<br>**NO DECALCIFIED BONE!** | Slides - **NO BLOCKS** | Copy of Pathology report and patient/hospital billing information MUST BE INCLUDED with slides. |
| Urine (Bladder Cancer)<br>*For UroVysion Studies ONLY* | ≥ 30 mL (50 mL preferred) | 50 mL centrifuge tubes or other tightly capped plastic container. | **Keep at room temperature.**<br><br>Include copy of pathology report. |
| Biliary Brushing<br>*For UroVysion Studies ONLY* | Specimen from endoscopic retrograde cholangiopancrea-tography (ERCP) brushing | ThinPrep PreservCyt® Solution from Hologic (containers provided by the Cytogenetics Laboratory) | **Keep at room temperature.** Ship to laboratory within 24 hours. Refrigerate if there is a delay in shipping. Include copy of pathology report. |

## 6) SPECIMEN HANDLING REQUIREMENTS

- Use sterile technique; close all containers tightly.
- **Do not freeze any specimen type.**
- Label all containers and requisition forms with patient name, MRN, date of collection, and physician name.
- **Specimens should be received within 24 hours of collection.**

## 7) PATIENT BILLING INFORMATION:

☐ Bill Patient's Insurance: Policy #: _____ Group #: _____

Insurance/Managed Care Plan: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Other: _____ Insured's Social Security #: _____

☐ ***OR*** Copy of patient's insurance card attached

☐ Bill Medicare: _____

☐ Bill Medicaid: _____

☐ Bill Patient/Self-Pay *(Please Attach Patient Demographic Sheet)*

☐ Bill Hospital: _____