WARDE MEDICAL LABORATORY
HEMATOLOGIC & NEOPLASTIC DISORDERS
CYTOGENETICS/FISH TEST REQUISITION

734-214-0300 800-760-9969 Fax: 734-214-0399

Patient Information

Name: _____
Last First MI

Date of Birth: _____/_____/_____ Gender: _____

Patient ID: _____ Specimen ID: _____

*Referring Physician: _____ * Phone: _____

Pathologist_____ Phone: _____

*Indication for Test / Clinical Information: _____

Test Requests/Specimen Type

☐ Chromosome Analysis, Hematologic Disorder (CHRL): Bone Marrow (3.0 mL minimum) or 10 mL Whole Blood Na Heparin

☐ Chromosome Analysis, Solid Tumor (CHRST): Tissue in Tissue Transport Medium (TTM)

Fluorescence *in situ* hybridization (FISH):

☐ Acute Myeloid Leukemia Panel
☐ Plasma Cell Myeloma Complete Panel w/ IGH reflex
☐ Chronic Lymphocytic Leukemia Panel
☐ MDS Panel
☐ Acute Lymphoblastic Leukemia Panel, Pediatric
☐ Acute Lymphoblastic Leukemia Panel, Adult (CDKN2A, BCR/ABL1, KMT2A)
☐ MALT Lymphoma Study (Chromosome 3, MALT1)
☐ Marginal Zone Lymphoma Panel (BCL6, 7p/7q, CEP12)
☐ BCR/ABL1 [t(9;22)]
☐ PML/RARA [t(15;17)]
☐ IGH/BCL2 [t(14;18)]
☐ CCND1 (BCL1)/IGH [t(11;14)]
☐ High Grade Lymphoma Panel (MYC, MYC/IGH, IGH/BCL2, BCL6)
  ☐ Perform as reflex (MYC, MYC/IGH first, stop if negative)

☐ RUNX1T1/RUNX1 [t(8;21)]
☐ CBFB/MYH11 [inv(16) & t(16:16)]
☐ MYC/IGH [t(8;14)]
☐ ALK (2p23)
☐ BCL6 (3q27)
☐ Eosinophilia Panel
  ☐ PDGFRA
  ☐ PDGFRB
  ☐ FGFR1
  ☐ JAK2
☐ KMT2A (MLL, 11q23)
☐ T-cell alpha/delta receptor
☐ Other FISH (Specify):_____

☐ Permission to sacrifice block
☐ Reflex to FISH testing above as necessary.
☐ Reflex to FLT3/NPM1/CEBPA/RUNX1 PCR if cytogenetics and FISH are negative. Reflex to KIT for t(8;21) or inv(16) or to FLT3 for t(15;17)/PML-RARA.
☐ Chromosome Hold

Specimen Type: _____

Collection Date: _____ Time: _____

Additional Comments: _____

_____

* Required Fields