

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 (CHRTU): Tissue in Tissue Transport Medium (TTM)

Fluorescence *in situ* hybridization (FISH):

- | | |
|--|---|
| <input type="checkbox"/> Acute Myeloid Leukemia Panel | <input type="checkbox"/> RUNX1T1/RUNX1 [t(8;21)] |
| <input type="checkbox"/> Plasma Cell Myeloma Complete Panel w/ IGH reflex | <input type="checkbox"/> CBFMB/MYH11 [inv(16) & t(16;16)] |
| <input type="checkbox"/> Chronic Lymphocytic Leukemia Panel | <input type="checkbox"/> MYC/IGH [t(8;14)] |
| <input type="checkbox"/> MDS Panel | <input type="checkbox"/> ALK (2p23) |
| <input type="checkbox"/> Acute Lymphoblastic Leukemia Panel, Pediatric | <input type="checkbox"/> BCL6 (3q27) |
| <input type="checkbox"/> Acute Lymphoblastic Leukemia Panel, Adult (CDKN2A, BCR/ABL1, KMT2A) | <input type="checkbox"/> Eosinophilia Panel |
| <input type="checkbox"/> MALT Lymphoma Study (Chromosome 3, MALT1) | <input type="checkbox"/> PDGFRA |
| <input type="checkbox"/> Marginal Zone Lymphoma Panel (BCL6, 7p/7q, CEP12) | <input type="checkbox"/> PDGFRB |
| <input type="checkbox"/> BCR/ABL1 [t(9;22)] | <input type="checkbox"/> FGFR1 |
| <input type="checkbox"/> PML/RARA [t(15;17)] | <input type="checkbox"/> KMT2A (MLL, 11q23) |
| <input type="checkbox"/> IGH/BCL2 [t(14;18)] | <input type="checkbox"/> T-cell alpha/delta receptor |
| <input type="checkbox"/> CCND1 (BCL1)/IGH [t(11;14)] | |
| <input type="checkbox"/> High Grade Lymphoma Panel (MYC, MYC/IGH, IGH/BCL2, BCL6) | <input type="checkbox"/> Other FISH (Specify): _____ |
| <input type="checkbox"/> Perform as reflex (MYC, MYC/IGH first, stop if negative) | |

- Permission to sacrifice block
- Reflex to FISH testing above as necessary.**
- Reflex to FLT3/NPM1/CEBPA 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 (CHOLD)

Specimen Type: Peripheral blood Bone marrow Paraffin-embedded tissue Tissue (TTM)

Collection Date: _____ Time: _____

Additional Comments: _____

* Required Fields