HENRY FORD HEALTH®
CENTER FOR PRECISION DIAGNOSTICS

Pathology and Laboratory Medicine
Clinic Building, K6, Core Lab, E-655
2799 W. Grand Blvd.
Detroit, MI 48202
855.916.4DNA (4362)

HEMATOLOGY/ONCOLOGY CYTOGENOMICS REQUISITION

Required Patient Information

Name: _____ Gender: M F

MRN: _____ DOB: MM / DD / YYYY

ICD10 Code(s): _____/_____/_____

ICD-10 Codes are required for billing. When ordering tests for which reimbursement will be sought, order only those tests that are medically necessary for the diagnosis and treatment of the patient.

Ordering Physician Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

NPI: _____

Billing & Collection Information

Patient Demographic/Billing/Insurance Form is required to be submitted with this form. Most genetic testing requires insurance prior authorization. Due to high insurance deductibles and member policy benefits, patients may elect to self-pay. Call for more information (855.916.4362)

❑ Bill Client or Institution Client Name: _____ Client Code/Number: _____

❑ Bill Insurance Prior authorization or reference number: _____

❑ Patient Self-Pay Call for pricing and payment options Toll Free: 855.916.4362

Patient status at time of collection: ❑ Inpatient ❑ Outpatient Collection date: _____ Collection time: _____

Providers are responsible to obtain informed consent, as required by Michigan law, for predictive or pre-symptomatic genetic tests. Informed Consent for Genetic Testing form is available on our website.

Specimen/Source

❑ Bone marrow aspirate (3 – 5mL in sodium heparin/dark green)
❑ Peripheral blood (10mL in sodium heparin, dark green tube)
❑ Lymph node (sterile media, Ringer's lactate or saline)
❑ Tumor (sterile media, Ringer's lactate or saline) Source: _____
❑ Paraffin sections (3 – 4 micron sections on charged slides) Source: _____

Pathology #: _____ Duration in Fixative: _____

❑ Touch preps/Imprints Source:_____ Pathology #:_____
❑ Other:
❑ Extracted DNA – Source: _____
(provide CLIA certificate of lab that performed the DNA extraction)

Indication for Testing

❑ New diagnosis
❑ AML: FAB type _____
❑ CML
❑ ALL Type: _____
❑ MDS
❑ MPN
❑ Other:
❑ S/P Chemo
❑ Post BMT
❑ Autologous ❑ Male Donor ❑ Female Donor

❑ CLL/SLL
❑ Multiple Myeloma
❑ B Cell Lymphoma Type: _____
❑ T Cell Lymphoma: Type: _____

Test(s) Requested

Some testing includes pathologist interpretation at a separate, additional charge.

❑ Chromosome Analysis (Karyotype) (Blood, Bone Marrow or Lymph Node: 88237x2, 88264, 88280, 88291; Tumor: 88239, 88264, 88280, 88291)
❑ Microarray (81277)
❑ FISH Leukemic Blood testing (88271x10, 88275x5)
❑ FISH Bile Tract Malignancy (88377)
❑ UroVysion (88120)
❑ FISH Bone Marrow Aspirate/Tumor/Lymph Node (88271x10, 88275x5)
❑ Custom FISH to detect previous abnormal clone (if available by patient history), select panel and/or probes below

Panels for New Diagnosis

❑ ALL: t(9;22), 11q23, t(12;21), +4, +10, +17
❑ AML: t(8;21), t(15;17), inv(16), 11q23 (KMT2A), 17p- TP53
❑ MDS: -5/5q-, -7/7q-, +8, 11q23 (KMT2A), 13q-, 20q-, 17p- TP53
❑ MPN: -5/5q-, -7/7q-, +8, 13q-, 20q-, +21, t(9;22)
❑ CMML: 4q12 PDGFRa, 5q32 PDGFRb, 8p FGFR1, t(9;22)

❑ Lymphoma: ☐B-NHL ☐MALT/MZL ☐SMZL
❑ CLL: +12, 11q-, 13q-, t(11;14), p53
Note: if indicated, reflex to 14q32 IGH breakapart
❑ Myeloma: -1p/1q+, 8q24 MYC, 13q-, t(11;14), 17p- TP53
Note: if indicated, may reflex to 14q32 IGH, t(4;14), t(14;16), t(6;14), t(14;20)

Individual Probes

❑ 13q14 deletion
❑ 11q22 ATM deletion
❑ 17p13.1 TP53 deletion
❑ +12 (CLL, B cell)
❑ t(9;22) – BCR/ABL
❑ 9p24 JAK2
❑ Xp22.33 CRLF2
❑ t(6;14) CCND3::IGH
❑ Monosomy 5 or 5q-
❑ Monosomy 7 or 7q-
❑ Trisomy 8 & 20q-
❑ 3q26.3 EVI1
❑ inv(16) CBFB
❑ t(15;17) PML/RARA
❑ t(8;21) RUNX1T1/RUNX1
❑ 1p CDKN2C/1q CKS1B
❑ t(14;20) IGH::MAFB
❑ 3q26 BCL6
❑ 8q24 MYC
❑ t(8;14) MYC::IGH
❑ t(11;14) Mantle cell
❑ +3 MALT
❑ t(11;18) BIRC3::MALT1
❑ t(14;18) Follicular
❑ 22q11.2 IGL
❑ 2p11.2 IGK
❑ FIP1L1-CHIC2-PDGFRa (4q12)
❑ PDGFRb (5q33)
❑ FGFR1 (8p12)
❑ Xp11.2 TFE3
❑ 6p21.2 TFEB
❑ t(12;21) – Pediatric ALL
❑ 11q23 MLL
❑ 6p25 DUSP22 (IRF4 or MUM1)
❑ 2p23 ALK
❑ 2p24.1 nMYC
❑ 10q11.2 RET
❑ 7q31.2 MET
❑ 1p/19q glioma
❑ 7p12 EGFR
❑ HER2 gene amp
❑ 14q32 IGH
❑ 22q12 EWSR1
❑ 12p13 ETV6
❑ 12q13 DDIT3
❑ 16p11 FUS
❑ 18q21 SS18
❑ 12q15 MDM2
❑ 3q28 TP63

Other FISH testing

Send Additional Report To

Name:
Address:
Phone #: Fax #:

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INFORMED CONSENT FOR GENETIC TESTING

Required Patient Information

Patient Last Name: _____ First Name: _____ MI init: _____

DOB: _____/ _____/ _____ PATIENT ID/MEDICAL RECORD NUMBER: _____

Ordering Provider Information (Full Name Last, First)

_____

Sample Type

- ❑ Amniotic Fluid
- ❑ Blood
- ❑ Cheek Swab
- ❑ Chorionic villus sample (CVS)
- ❑ Skin
- ❑ Tissue Block

❑ Other: _____

Genetic Testing Requested For:

_____
(name of condition)

The intended purpose is (check all that apply):

- ❑ Carrier status
- ❑ Diagnostic
- ❑ Predictive
- ❑ Prenatal
- ❑ Pre-symptomatic
- ❑ Screening
- ❑ Other: _____

1. I have been informed about the nature and the purpose of this genetic testing.
2. I have received an explanation of the effectiveness and limitations of this genetic testing.
3. I have discussed the benefits and risks of this genetic test with my physician and/or other health care professional. I understand some genetic tests can involve possible medical, psychological, or insurance issues for my family and I.
4. I understand the meaning of possible test results and have been informed how I will receive the result.
5. I have been informed that genetic testing can sometimes reveal secondary findings-results that are not related to the purpose of testing. I have discussed with my health care professional if and/or how such results will be shared with me. I understand that it us up to me to decide whether I want secondary results reported back to me and what secondary results I want reported.
6. If ordered by the ordering provider above, I authorize supplemental genetic testing to further aid in diagnosis, treatment and/or risk evaluation(s).
7. I have been informed who may have access to my biological sample, and that any remaining sample may be retained by the laboratory.
8. I have been informed who may have access to my genetic test result(s), which is part of my confidential medical record.
9. My questions have been answered to my satisfaction.
10. I understand that this consent form is intended to be used together with the patient information booklet that contains important information explaining the above eight items. I have read this consent form and understand that I can access the booklet electronically at: https://www.Michigan.gov/documents/InformedConsent_69182_7.pdf
11. I received a copy of this form for my records

I consent to have a sample taken for genetic testing on the above-named patient for the condition(s) listed above.

_____ _____
Signature of Patient or Authorized Designee *Date*

Circle one: ***Self*** ***Parent(s)*** ***Legal Guardian*** ***Durable Power of Attorney for Health Care***

Print Name of Physician or Authorized Delegee explaining the above information:

_____ _____
Signature of Authorized Person *Date*