2011

MOLECULAR CYTOGENETIC REFERRAL FORM FOR FISH ANALYSIS

Medical Genetics – Wake Forest University School of Medicine – Winston Salem NC
www.wfubmc.edu/medicalgenetics Phone: 336-716-4321 Fax: 336-716-2554

Collection Date: _____ **Time**: _____ am/pm **Time of Fixation** _____

Name: _____/_____/_____/_____
(Please print) Last First Middle Maiden

Address: _____/_____/_____/_____ **Daytime Phone:**(____)_____
Mailing Address City State Zip

Birth Date: _____ **SS# or Patient ID #**: _____ **Sex**: ☐ male ☐ female

Hospital: _____ **Hospital/Unit #:** _____

Type of Specimen ☐ **Amnio** ☐ **CVS** ☐ **Tissue** ☐ **PUBS** ☐ **POC** ☐ **Urine** ☐ **Blood** ☐ **Bone Marrow**
☐ **Solid Tumor** ☐ **Slides/Smears** ☐ **Paraffin Block** ☐ **Other:** _____

Collection Technique: Green stoppered sodium heparin tube. **Room temperature**

Physician/Provider Order

Physician: Last, First / Phone/beeper

1.	
X.	
X. Physician Signature Required	
3	
4	

Statement of Financial Responsibility

I authorize any holder of medical or other information about me to release to my healthcare provider, third party processor, the Centers for Medicare and Medicaid Services or its intermediaries or carriers any information needed for this health care encounter or related claim. I permit a copy of this authorization to be used in place of the original, and request payment of authorized insurance benefits be made on my behalf to the WFU Physicians. I understand I am responsible for payment of these charges. I am also responsible for payment if my insurance carrier decides this is a non-covered service or requires prior authorization, which I did not obtain.

Patient Signature: _____ **Date:** _____

Billing Information

Bill: ☐ Forsyth Hospital ☐ Moses Cone Hospital
☐ Spectrum ☐ Women's Hosp of Greensboro ☐ Wesley Long Hospital ☐ Other : _____
☐ Medicare # _____ ☐ Medicaid #: _____ ☐ Carolina Access #: _____
☐ Insurance: _____ Employer: _____ Policy #:_____
(Enclose copy of both sides of insurance card)

Signs/Symptoms/Indication (ICD-9 Codes) for Chromosome Study

Indicate **all** that apply. **Codes here do not represent entire listing of ICD-9 codes available**. Please consult current ICD-9 code book for complete listing.

LEUKEMIA

☐ ALL (204.00) ☐ remission (.01)
☐ Acute Leukemia (206.00)
☐ Leukemia unspec (208.80)
☐ AML (205.00) ☐ remission (.01)
☐ APL (205.00) ☐ remission (.01)
☐ Burkitt's Lymphoma unspec (200.20)
☐ Non-Hodgkins (202.80)
☐ CML (205.10) ☐ remission (.01)
☐ MDS (238.75)
☐ CLL (204.10)
☐ Hodgkin's Lymphoma unspec (201.90)
☐ Multiple Myeloma (203.00) ☐ remission (.01)
☐ Myeloproliferative Syndrome (238.72)
☐ Thrombocythemia (238.71)
☐ Other (specify): _____

PRENATAL

☐ Advanced Maternal Age (659.63)
☐ Inc. Down Syndrome Risk (796.5)
☐ Inc. Trisomy 18 Risk (796.5)
☐ Suspected fetal chromosome abn (655.13)
☐Abn. Ultrasound – specify _____
☐ Other (specify): _____

POSTNATAL

☐ Unspecified congenital anomaly (759.9)
☐ Multiple congenital anomalies (759.7)
☐ Sex chromosome anomaly (758.81)
☐ Cleft lip/palate (749.20)
☐ Ambiguous genitalia (752.9)
☐ Delay in sexual development (259.0)

OTHER

☐ Malig of breast (174.1)
☐ Neoplasm of bladder (239.4)
☐ Malign neoplasm of bladder wall NOS (188.9)
☐ Post BMT transplant (V42.81)
Specify original disease:_____
☐ Other (specify): _____

Test Requested

Note: When ordering tests for which **Medicare** reimbursement will be sought, it is recommended that the Provider consult any Local Medical Review Policies (**LMRP**) or National Coverage Decisions (**NCD**) that may be applicable to the test(s) being ordered. Based on guidance issued in either of these policies it may be necessary to obtain an Advanced Beneficiary Notice (**ABN**) from the Medicare Patient.Form Medicaid and other carriers a signed **Statement of Financial Responsibility** from the patient may be necessary . (See Statement of Financial Responsibility at top of form.)

FISH Probes – select as needed

Prenatal

☐ 13/18/21/X/Y
☐ +13 LSI
☐ +21 LSI
☐ +18 LSI
☐ +/- X
☐ +/- Y

Syndrome/Microdeletion

☐ Angelman 15q11
☐ Cri-du-chat 5p15.2
☐ DiGeorge/VCF 22q11
☐ Williams 7q11.23
☐ Kallmann Xp22.3
☐ Miller-Dieker 17p13.3
☐ Prader-Willi 15q11
☐ Retinoblastoma 13q14
☐ Smith-Magenis 17p11.2
☐ Wolf-Hirschhorn 4p16.3
☐ Trisomy 21
☐ Trisomy 13
☐ Trisomy 18
☐ Turner 45, X
☐ Klinefelter 47, XXY
☐ Sex Chromosome
☐ SRY Yp11.3
☐ STS Xp22.3
☐ Subtelomere

Leukemia / Tumor

☐ +8 (AML)
☐ +12 (CLL)
☐ +4/+10/+17 (ALL)
☐ -5 / del 5q31
☐-7 / del 7q31
☐ del 20q12.2
☐ inv (16)
☐ X/Y (transplant)
☐ BCR/ABL (9;22-CML)
☐ PML/RARA (15;17-APL)
☐ Brain (1pq19pq)
☐ MYB 6q
☐ MYC 8q
☐ MDM2
☐ BCL-6
☐ TEL/AML t(12;21)
☐ Mantle Cell t(11;14)
☐ MLL (11q23)
☐ Burkitts t(8;14)
☐ MALT (18q)
☐ Follicular t(14;18)
☐ AML t(8;21)
☐ Ewings Sarcoma (22q12)
☐ SYT Synovial arc.(X;18)
☐ ETV6 12p
☐ ALK t(2;5)
☐ BCR/ABL and ASS

Panels

☐ B-ALL
☐ Uro Vysion-Bladder
☐ Her2/neu-breast
☐ CLL Panel
☐ Mult. Myeloma

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Collection Date: _____ **Time**: _____ am/pm **Time of Fixation** _____

MOLECULAR CYTOGENETIC LAB USE ONLY

Name:_____ **Lab #**_____

Date Received:_____/_____/_____ **Time Received**: _____

Additional Specimen Evaluation:_____

_____

Additional Samples Received: [ ] DNA: _____ { } FRAX [ ] FISH [ ] other_____

LABORATORY REPORT SUMMARY

Date culture initiated: _____/_____/_____ **Tech:** _____

Sample type: [ ] PB [ ] FISH [ ] FRAX [ ] PUBS [ ] BM stat

Culture: [ ] 48h. [ ] 72h. col. [ ] 72h.EtBr [ ] DBM [ ] 24h [ ] 96h.

Media: [ ] RPMI 1640 less folic acid [ ] RPMI 1640

REPORT OF RESULTS / SPECIMEN SUMMARY

[ ] Final [ ] Preliminary [ ] Read Back Date_____Tech_____

To:_____

INTERPRETATION: [ ] normal [ ] abnormal:_____

Abnormality:

[ ] +13 [ ] +18 [ ]+21 [ ] X [ ] Y

[ ] Williams 7q22 [ ] DiGeorge/VCF 22q11 [ ] Prader-Willi 15q12 [ ] Angelman 15q12
[ ] Smith-Magines 17p11 [ ] Miller-Dieker 17p13 [ ] STS Xp22.3
[ ] Subtelomere :_____ [ ] MFISH chromosome _____

☐ t(9;22 ☐ +8 ☐ t(15;17) ☐ +4 /+10 /+17 ☐ inv(16) ☐ 20q- ☐ t(12;21)
☐ t(8;21) ☐ t(8;21) ☐ 11q23abn ☐ t(2;5) ☐ -5/5q ☐ -7/7q ☐ 6q-
☐ t(11;14) ☐ t(14;18) ☐ t(8;14) ☐ t(1;19) ☐ 11;22 ☐ 11q- ☐ inv(3)
☐ X/Y **BM transplant** ☐ t(18q21) ☐ MYC ☐ 3q

☐ Her 2 Neu **breast** ☐ Bladder panel ☐ CLL **(17p-/+12/13q-/11q)**

T_____ By:_____Date_____