2015 CANCER REFERRAL FORM FOR CHROMOSOME 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 **WFU LAB #:** _____

Name: _____/_____/_____ **Sex:** ☐ male / ☐ female
(Please print) **Last** **First** **Middle**

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

Date of Birth: _____ **SS# :** _____

Hospital and Unit #: _____

Type of Specimen: ☐ **Bone Marrow** ☐ **Bone Core** ☐ **Blood** ☐ **FNA** ☐ **Pleural Fluid** ☐ **Lymph node**
☐ **Solid tumor (type):** _____ ☐ **Other:**_____

COLLECTION TECHNIQUE: Bone marrow is collected using preservative free sodium heparin and placed in lab provided media. Blood is collected in a green stoppered sodium heparin tube. **Keep all samples at room temperature**.

Physician/Provider Order

Physician: Last, First / Phone/Beeper

1.	
X	
X Physician Signature Required	
2.	
3.	

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/Novant ☐ Moses Cone Hospital ☐ Moses Cone / Solstas
☐ Solstas ☐ Women's Hospt. 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 listing of ICD-9 codes available**. Please consult current ICD-9 code book for complete listing.

☐ ALL (204.00) ☐ remission (.01)
DI:_____{ }B-cell { }T- cell
☐ Acute leukemia (206.00) ☐ remission (.01)
☐ AML (205.00) ☐ remission (.01)
☐ APL (205.00) ☐ remission (.01)
☐ Anemia (285.9)
☐ Burkitt's Lymphoma (200.20) unspec.
☐ CML (205.10 ☐ remission (.01)
☐ CLL (204.10)
☐ Hodgkin's Lymphoma (201.90) unspecif. Site
☐ Myeloproliferative Syndrome (238.79)

☐ Leukocytosis (288.8)
☐ Leukopenia (288.50)
☐ Leukemia (208.00) unspec .
☐ Lymphoma (202.80) unspec.
☐ Lymphocytosis (288.8)
☐ Plasma cell leukemia (203.10)
☐ Multiple myeloma (203.00) ☐ remis (.01)
☐ MDS (238.75) ☐ 5q- (238.74)
☐ Myelofibrosis (289.89)
☐ PCV (238.4)
☐ Suspected chromosome abn (758.9)

☐ Neutropenia (288.00)
☐ Non-Hodgkin's (202.80)
☐ Pancytopenia (284.89)
☐ Thrombocytosis (289.9)
☐ Thrombocytopenia (287.5)
☐ Tumor specify_____
☐ Sarcoma specify_____
☐ Transplant (V42.81)
specify original disease:_____
[ ] autologous { }male / { } female
[ ] allogenic

☐ **Additional ICD-9/ Clinical Information**:_____

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. For 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.)

TEST(s) REQUESTED

☐ **Routine Chromosome / karyotype**
(88237 ,88262 ,88280 ,88285)
☐ **STAT Chromosomes** *(48 hrs.)*
(88237, 88262, 88280, 88285, 88261)
☐ **Routine Chromosome + FISH** **select →**
(88237, ,88262 ,88280 ,88285, 88271x_ , 88275)
☐ **STAT FISH (24hrs) / Chromosome** **select →**
(88271x_ , 88275, 88237 ,88262 ,88280 ,88285)
☐ **FISH Only** **select →**
(88271x_ , 88275)
☐ **Paraffin-embedded slide - FISH** **select →**
(88271x2, 88275, 88299)

PROTOCOL: ☐ CALGB ☐ COG
☐ **ECOG** ☐ **SWOG**

FISH Specific Probes

☐ t(9;22) **BCR/ABL**	☐ t(1;19) PBX1/TCF3	☐ **Ewings Sarcoma Panel**
☐ BCR/ABL and ASS	☐ +4 /+10 /+17 **ALL**	☐ Her 2 Neu **breast**
☐ inv(16) **AML-M4EO**	☐ 20q- **PCV**	☐ **Eosinophilia panel**
☐ t(12;21) **TEL/AML**	☐ inv(14)	☐ Bladder panel
☐ t(15;17) **PML/RARA**	☐ CHOP (12q13)	☐ CLL
☐ t(8;21) **AML1/ETO**	☐ FGFR1 (8p12	☐ mult myeloma panel
☐ 11q23 **MLL**	☐ CDKN2A (9p21)	☐ t(2;5) ALK **Anaplastic**
☐ -5/5q **MDS / AML**	☐ inv(3q)	☐ liposarcoma **MDM2**
☐ -7/7q **MDS / AML**	☐ **inv(14) TCL1**	☐
☐ **+8** **AML / MDS**	☐	☐ t(8;14) **Burkitts**
☐ X/Y **BM transplant**	☐ t(18q21) **MALT**	☐ **(**14;18) BCL2**Follicular**
☐ MYC 8q **lymphomas**	☐ 3q abn **BCL6**	☐ t(11;14) **Mantle cell**
☐ **t(6;9) AML**	☐	☐ SYT 18 **Synovial Sarc**
☐ 6q **MYB**	☐ PDGFRB	☐
☐ 12p (ETV6)	☐ PDGFRA/CHIC2/FIPL1	☐
☐ X/Y (transplant)	☐_____	☐

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Collection Date: _____ **Time**: _____ am/pm **WFU LAB #:** _____

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**: _____

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

Count_____ (x 0.02) = _____x 10^6 cell/ml = _____ml sample/flask or ____ml centrifuged sample into

Sample type: [ ] BM [ ] UPB [ ] BC [ ] FNA [ ] Other_____

Culture: [ ] Direct [ ] 24h. [ ] 24h+ovnt COL [ ] 24h pokeweed [ ] 48h.

[ ] 48h. Pokeweed [ ] 72h . [ ] 72h.Pokeweed [ ] 96h. [ ] IL-4

REPORT OF RESULTS / SPECIMEN SUMMARY

[ ] Final [ ] Preliminary [ ] Read Back Date_____Tech_____

To:_____

KARYOTYPE: [ ] 46,XY [ ] 46,XX

INTERPRETATION: [ ] normal male [ ] normal female

[ ] abnormal:_____

_____

Additional Studies / Results: [ ] NOR [ ] C-band [ ] R-band

FISH: [ ] normal male [ ] normal female

Abnormality:_____

☐ t(9;22 ☐ +8 ☐ t(15;17) ☐ +4 /+10 /+17 ☐ inv(16) ☐ 20q- ☐ t(12;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)** ☐ MM panel **(4p/16q-//13q-/11q/17p)**

To:_____By:_____ Date_____