

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 InformationBill: 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.

- | | | |
|--|---|---|
| <input type="checkbox"/> ALL (204.00) <input type="checkbox"/> remission (.01)
DI: _____ { }B-cell { }T- cell | <input type="checkbox"/> Leukocytosis (288.8) | <input type="checkbox"/> Neutropenia (288.00) |
| <input type="checkbox"/> Acute leukemia (206.00) <input type="checkbox"/> remission (.01) | <input type="checkbox"/> Leukopenia (288.50) | <input type="checkbox"/> Non-Hodgkin's (202.80) |
| <input type="checkbox"/> AML (205.00) <input type="checkbox"/> remission (.01) | <input type="checkbox"/> Leukemia (208.00) unspec . | <input type="checkbox"/> Pancytopenia (284.89) |
| <input type="checkbox"/> APL (205.00) <input type="checkbox"/> remission (.01) | <input type="checkbox"/> Lymphoma (202.80) unspec. | <input type="checkbox"/> Thrombocytosis (289.9) |
| <input type="checkbox"/> Anemia (285.9) | <input type="checkbox"/> Lymphocytosis (288.8) | <input type="checkbox"/> Thrombocytopenia (287.5) |
| <input type="checkbox"/> Burkitt's Lymphoma (200.20) unspec. | <input type="checkbox"/> Plasma cell leukemia (203.10) | <input type="checkbox"/> Tumor specify _____ |
| <input type="checkbox"/> CML (205.10) <input type="checkbox"/> remission (.01) | <input type="checkbox"/> Multiple myeloma (203.00) <input type="checkbox"/> remis (.01) | <input type="checkbox"/> Sarcoma specify _____ |
| <input type="checkbox"/> CLL (204.10) | <input type="checkbox"/> MDS (238.75) <input type="checkbox"/> 5q- (238.74) | <input type="checkbox"/> Transplant (V42.81) |
| <input type="checkbox"/> Hodgkin's Lymphoma (201.90) unspecif. Site | <input type="checkbox"/> Myelofibrosis (289.89) | specify original disease: _____ |
| <input type="checkbox"/> Myeloproliferative Syndrome (238.79) | <input type="checkbox"/> PCV (238.4) | [] autologous { } male / { } female |
| <input type="checkbox"/> Additional ICD-9/ Clinical Information: _____ | <input type="checkbox"/> Suspected chromosome abn (758.9) | [] allogenic |

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

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

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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 acidCount _____ (x 0.02) = _____ x 10⁶ cell/ml = _____ ml sample/flask or _____ ml centrifuged sample intoSample 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,XXINTERPRETATION: normal male normal female abnormal: _____Additional Studies / Results: NOR C-band R-bandFISH: normal male normal female

Abnormality: _____

- | | | | | | | |
|--|--|--|---------------------------------------|---|-------------------------------|-----------------------------------|
| <input type="checkbox"/> t(9;22) | <input type="checkbox"/> +8 | <input type="checkbox"/> t(15;17) | <input type="checkbox"/> +4 /+10 /+17 | <input type="checkbox"/> inv(16) | <input type="checkbox"/> 20q- | <input type="checkbox"/> t(12;21) |
| <input type="checkbox"/> t(8;21) | <input type="checkbox"/> 11q23abn | <input type="checkbox"/> t(2;5) | <input type="checkbox"/> -5/5q | <input type="checkbox"/> -7/7q | <input type="checkbox"/> 6q- | <input type="checkbox"/> inv(3) |
| <input type="checkbox"/> t(11;14) | <input type="checkbox"/> t(14;18) | <input type="checkbox"/> t(8;14) | <input type="checkbox"/> t(1;19) | <input type="checkbox"/> 11;22 | <input type="checkbox"/> 11q- | |
| <input type="checkbox"/> X/Y BM transplant | | | | | | |
| <input type="checkbox"/> t(18q21) | <input type="checkbox"/> MYC | <input type="checkbox"/> 3q | | | | |
| <input type="checkbox"/> Her 2 Neu breast | <input type="checkbox"/> Bladder panel | <input type="checkbox"/> CLL (17p-/+12/13q-/11q) | | <input type="checkbox"/> MM panel (4p/16q-//13q-/11q/17p) | | |

To: _____ By: _____ Date _____