

2010 **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 Paraffin Block Other: _____

Collection Technique: Green stoppered sodium heparin tube. Room temperature

Physician Information		Statement of Financial Responsibility
Physician: Last, First	Phone/beeper	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.
1		
2		
3		
		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	POSTNATAL	OTHER
<input type="checkbox"/> Advanced Maternal Age (659.63) <input type="checkbox"/> Inc. Down Syndrome Risk (796.5) <input type="checkbox"/> Inc. Trisomy 18 Risk (796.5) <input type="checkbox"/> Suspected fetal chromosome abn (655.13) <input type="checkbox"/> Abn. Ultrasound – specify _____ <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Unspecified congenital anomaly (759.9) <input type="checkbox"/> Multiple congenital anomalies (759.7) <input type="checkbox"/> Sex chromosome anomaly (758.81) <input type="checkbox"/> Cleft lip/palate (749.20) <input type="checkbox"/> Ambiguous genitalia (752.9) <input type="checkbox"/> Delay in sexual development (259.0)	<input type="checkbox"/> Malign of breast (174.1) <input type="checkbox"/> Neoplasm of bladder (239.4) <input type="checkbox"/> Malign neoplasm of bladder wall NOS (188.9) <input type="checkbox"/> Post BMT transplant (V42.81) Specify original disease: _____ <input type="checkbox"/> 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	Syndrome/Microdeletion	Leukemia / Tumor	Panels
<input type="checkbox"/> 13/18/21/X/Y <input type="checkbox"/> +13 LSI <input type="checkbox"/> +21 LSI <input type="checkbox"/> +18 LSI <input type="checkbox"/> +/- X <input type="checkbox"/> +/- Y	<input type="checkbox"/> Angelman 15q11 <input type="checkbox"/> Cri-du-chat 5p15.2 <input type="checkbox"/> DiGeorge/VCF 22q11 <input type="checkbox"/> Williams 7q11.23 <input type="checkbox"/> Kallman Xp22.3 <input type="checkbox"/> Miller-Dieker 17p13.3 <input type="checkbox"/> Prader-Willi 15q11 <input type="checkbox"/> Retinoblastoma 13q14 <input type="checkbox"/> Smith-Magenis 17p11.2 <input type="checkbox"/> Wolf-Hirschhorn 4p16.3 <input type="checkbox"/> Trisomy 21 <input type="checkbox"/> Trisomy 13 <input type="checkbox"/> Trisomy 18 <input type="checkbox"/> Turner 45, X <input type="checkbox"/> Klinefelter 47, XXY <input type="checkbox"/> Sex Chromosome <input type="checkbox"/> SRY Yp11.3 <input type="checkbox"/> STS Xp22.3 <input type="checkbox"/> Subtelomere	<input type="checkbox"/> +8 (AML) <input type="checkbox"/> +12 (CLL) <input type="checkbox"/> +4/+10/+17 (ALL) <input type="checkbox"/> -5 / del 5q31 <input type="checkbox"/> -7 / del 7q31 <input type="checkbox"/> del 20q12.2 <input type="checkbox"/> inv (16) <input type="checkbox"/> X/Y (transplant) <input type="checkbox"/> BCR/ABL (9;22-CML) <input type="checkbox"/> PML/RARA (15;17-APL) <input type="checkbox"/> Brain (1p19pq) <input type="checkbox"/> MYB 6q <input type="checkbox"/> MYC 8q <input type="checkbox"/> BCL-6 <input type="checkbox"/> TEL/AML t(12;21) <input type="checkbox"/> Mantle Cell t(11;14) <input type="checkbox"/> MLL (11q23) <input type="checkbox"/> Burkitts t(8;14) <input type="checkbox"/> MALT (18q) <input type="checkbox"/> Follicular t(14;18) <input type="checkbox"/> AML t(8;21) <input type="checkbox"/> Ewings Sarcoma (22q12) <input type="checkbox"/> SYT Synovial arc.(X;18) <input type="checkbox"/> ETV6 12p <input type="checkbox"/> ALK t(2;5) <input type="checkbox"/> BCR/ABL and ASS	<input type="checkbox"/> M-FISH <input type="checkbox"/> Uro Vysion-Bladder <input type="checkbox"/> Her2/neu-breast <input type="checkbox"/> CLL Panel <input type="checkbox"/> 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 _____