UFHealth
PATHOLOGY LABORATORIES

ONCOLOGY CYTOGENETIC ANALYSIS REQUEST

Reference our other cytogenetics requisition forms for additional tests not listed here, or visit us online at:

pathlabs.ufl.edu/services/cytogenetics

University of Florida Health
Pathology Laboratories • Cytogenetics
4800 SW 35th Drive • Gainesville, FL 32608

Telephone: 352.265.9900
Toll-Free: 888.375.5227
Fax: 352.265.9920

Patient Demographic Information

Name: _____

Medical record #: _____

Age or DOB: _____

Sex/Gender: ☐ Female ☐ Male ☐ Unknown

Requesting Physician Information

Name: _____ NPI #: _____

Location/Institution: _____

Signature: _____

Send additional reports to: _____

Clinical Indication or Reason for Cytogenetic Testing

☐ APL (M3) ☐ AML ☐ B-ALL ☐ Pre B-ALL ☐ T-ALL ☐ Acute leukemia, nos

☐ Mixed-lineage leukemia ☐ CLL/SLL ☐ Plasma Cell Neoplasia - Subtype: _____

☐ CML ☐ MDS - Subtype: _____ ☐ MPD - Subtype: _____

☐ Lymphoma - Subtype: _____

☐ Solid tumor type: _____

☐ Other: _____

Specimen Information

☐ Bone marrow aspirate

☐ Bone marrow core biopsy

☐ Peripheral blood ☐ Lymphatic tissue

☐ Solid tumor

☐ Other: _____

Collection date: _____

Collection time: _____

☐ Post-therapy ☐ Post-transplant

☐ Remission ☐ Relapse

Immunophenotyping by FLOW:

☐ Was ordered ☐ Was not ordered

Cytogenetic Testing Requested *(must be completed to avoid delays in processing)*

☐ Conventional chromosome analysis ***ONLY***

☐ Conventional chromosome analysis **and** FISH ***as necessary***

Selected FISH Analyses

*Rows 1 – 7 reflect commonly grouped FISH panels: **1.** AML (non-M3); **2.** -ALL; **3.** -CLL/SLL; **4.** MM/MGUS/PCN; **5.** -MDS; **6.** -NHL; **7.** Tumors (non-fixed samples); **8.** Various*

APL ***CML***

☐ *PML/RARA (APL-M3)* ☐ *BCR/ABL1*

1. ☐ *KMT2A* (MLL) ☐ *CBFB* (16q22) ☐ *RUNX1/RUNX1T1*

2. ☐ *BCR/ABL1* ☐ *ETV6/RUNX1* ☐ *KMT2A* (MLL) ☐ TCF3/PBX1 ☐ *CDKN2A (9p21)* ☐ 4/10cen

3. ☐ del(13q) ☐ Trisomy 12 ☐ *ATM* (11q22) ☐ *TP53* (17p13)

4. ☐ CKSB1 (1q21) ☐ *IGH* (14q32)* ☐ *TP53* (17p13) ☐ del(13q)

☐ *IGH fusions (reflexed if IGH positive*)* ☐ *IGH/FGFR3** ☐ *IGH/CCND1** ☐ *IGH/MAF** ☐ *IGH/MYC**

5. ☐ 5q - del/mono ☐ 7q - del/mono ☐ Trisomy 8 ☐ 20q - deletion

6. ☐ *BCL6* (3q27) ☐ *MYC* (8q24) ☐ *BCL2* (18q21) ☐ *IGH/MYC** ☐ *IGH/CCND1* ☐ *IGH/BCL2*

7. ☐ *EWSR1* ☐ *SS18* ☐ *FOXO1* ☐ *MDM2* ☐ *FUS*

8. ☐ *BCR/ABL1* ☐ *ETV6* (12p13) ☐ X/Y – sex-mismatched transplant

☐ Other (inquire on availability): _____

For Lab Use Only

Lab #: _____

Specimen description: _____

# of containers: _____ *Quantity (ml):* _____

☐ *Sodium heparin tube*

Other:

_____

Additional test codes: _____

_____

Tech login ID: _____

Insurance/Billing Information *(must be completed prior to sample processing)*

Insurance provider: _____

Preauthorization required?: ☐ Yes ☐ No

If yes, provide the authorization number: _____