UF PathLabs
UNIVERSITY of FLORIDA

UF Cytogenetics Laboratory
4800 SW 35th Drive
Gainesville, FL 32608

ONCOLOGY CYTOGENETIC TESTING REQUISITION FORM

(please use the Standard or Prenatal Cytogenetic Request forms for all other studies)

Telephone: (352) 265-9900
Toll Free: 1-888-375-5227
FAX: (352) 265-9920
http://www.pathlabs.ufl.edu/

Patient Demographic Information

Name: _____

Medical Record No.: _____

Age or D.O.B.: _____

Sex/Gender: ☐Male ☐ Female ☐Unknown

Requesting Physician Information

Name:_____ NPI #:_____

Location/Institution: _____

Signature:_____

Send additional reports to: _____

Clinical Indication or Reason for Cytogenetic Testing

☐CML ☐AML ☐APL (M3) ☐precursor B-ALL

☐T-ALL ☐B-ALL ☐ALL, nos ☐Mixed lineage leukemia

☐Acute leukemia, nos ☐MPD - Subtype: _____

☐MDS - Subtype: _____

☐Multiple myeloma ☐Lymphoma - Subtype: _____

☐Solid tumor type: _____

☐Other: _____

Specimen Information

☐Bone marrow aspirate

☐Bone marrow core biopsy

☐Peripheral blood ☐ Lymphatic tissue

☐Solid tumor *(NO PARAFFIN BLOCKS)*

☐Other _____

Date Collected: _____

Time Collected: _____

☐ Post-therapy ☐ Post-transplant

☐ Remission ☐ Relapse

Immunophenotyping by FLOW:

☐ has been ordered ☐has not been ordered

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

UNFIXED TISSUES ONLY *- NO PARAFFIN BLOCKS OR FORMALIN PRESERVED*

☐ ***Conventional G-banded Chromosome Analyses (aka karyotyping)***

☐ ***FISH Analyses*** *- (all primary studies should include a conventional chromosome study)*
Rows 1-5 reflect commonly grouped "panels"
1 - MDS/MPD; 2 - MM/PCL; 3 - CLL/SLL; 4 - AML; 5 - ALL

☐*BCR/ABL1* ☐*PML/RARA* ☐ X/Y – sex mis-matched transplant

1☐5q - del/mono ☐7q - del/mono ☐Trisomy 8 ☐20q - deletion

2☐del(13q) ☐*IGH* (14q32) ☐*TP53* (17p13) ☐*IGH fusions (if positive*)*

3☐del(13q) ☐*IGH* (14q32) ☐*TP53* (17p13) ☐Trisomy 12 ☐*ATM* (11q22)

4☐*MLL* (11q23) ☐*CBFB* (16q22) ☐*RUNX1/RUNX1T1*

5☐*BCR/ABL1* ☐*ETV6/RUNX1* ☐*MLL* (11q23) ☐4/10/17 (B-ALL)

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

☐*ETV6* (12p13) ☐*IGH/CCND1** ☐*IGH/MAF** ☐*IGH/FGFR3** ☐*ALK* (2p23)

☐*FOXO1* (13q14) ☐*EWSR1* (22q12) ☐*SS18* (18q11.2)

INQUIRE FOR AVAILABILTY - OTHER:

For Lab Use Only

*Lab No.:*_____

Specimen Descriptor: _____

 # 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: _____

Pre-Authorization Required: ☐YES ☐NO

If Yes, Please provide Authorization Number: _____