HNL Lab Medicine

Cytogenetic and Molecular Oncology Test Requisition Form

Please print clearly and provide all requested information. HNL Lab Medicine cannot initiate testing unless this information is provided.

ORDERING PHYSICIAN REQUIRED

PATIENT INFORMATION

☐ FEMALE PATIENT ☐ MALE PATIENT

PATIENT NAME — LAST, FIRST, MI		LAST 4 DIGITS OF SOCIAL SECURITY NO.
DATE OF BIRTH (MM/DD/YYYY)	TELEPHONE NUMBER	
STREET NUMBER	STREET NAME	APT NUMBER
CITY	STATE	ZIP

SPECIMEN INFORMATION

ORDER DATE	COLLECTION DATE	COLLECTION TIME AM PM
SPECIMEN TYPE	SPECIMEN SOURCE	
DATE AND TIME OF RECEIPT (To be completed by HNL)		AM PM

ACKNOWLEDGEMENT: I authorize the laboratory to provide to my health plan the information on this form and other information provided by my healthcare provider if necessary for reimbursement. I understand that the laboratory may seek prior authorization for testing from my health plan on my behalf. I also authorize all benefits of the plan to be payable directly to the laboratory, and I agree to remit to the laboratory any payment for these services made directly to me. I understand that the laboratory may be an out-of-network provider for my health plan and that I am responsible for all amounts not reimbursed by my health plan. I hereby designate the laboratory as my Authorized Representative, as provided under ERISA, 29 C.F.R. § 2560.5031 (b)(4), and/or as my Attorney in Fact, for the purpose of pursuing administrative appeals to which I am entitled and, if the laboratory deems it appropriate, any legal and/or equitable claims that I could bring against my health plan, and/or its fiduciaries, and/or its administrators, with respect to their handling or resolution of my insurance claim. I authorize information to be shared with my partner if also undergoing testing.

☐ I AUTHORIZE the laboratory to retain and use my de-identified specimen and test data (where all information that could link me to the specimen or data has been removed) for research and/or help develop new products or services, in compliance with applicable laws.

☐ I DO NOT AUTHORIZE the laboratory to retain and use my de-identified specimen and test data as described above. If signature is present but box is not checked, consent is implied. All leftover specimens from New York State will be destroyed within 60 days.

REQUIRED PATIENT SIGNATURE X _____ DATE (MM/DD/YYYY) _____

PAYMENT INFORMATION

☐ SELF PAY (Also required for all insurance cases — please see "INSURANCE" below)

☐ CHECK ☐ M.O. Please make check or money order payable to HNL.

☐ INSURANCE In addition to completing the information below, be sure to provide a clear copy of both the front and back of your insurance card, and sign below.

NAME OF INSURED	RELATIONSHIP TO PATIENT	
INSURANCE ID NUMBER	GROUP NUMBER	
PRE-AUTHORIZATION NUMBER	DATE(S) AUTHORIZATION VALID	INSURANCE COMPANY PHONE NUMBER

Refer to the HNL Lab Handbook at www.HNL.com for a complete test listing of panels, collection requirements, and other methodologies available for testing, special instructions, and testing algorithms.

SPECIMEN REQUIREMENTS

Bone marrow aspirate	1–2 mL sodium heparin tube (No lithium heparin)
Peripheral Blood	1–2 mL sodium heparin tube (No lithium heparin)
FFPE Block	One H&E slide plus a minimum of two unstained slides cut at 5µm.
Hematology Oncology: NGS Myeloid panel, FLT3	1 mL EDTA blood or Bone Marrow Aspirate
Hematology Oncology: BCR-ABL	4 mLs EDTA blood
Hematology Oncology: JAK2	1 mL EDTA blood

ALL SPECIMENS SHOULD BE MAILED TO:

Cytogenetics / Molecular Department
794 Roble Road
Allentown, PA 18109

For any questions, please call customer care: +1-877-402-4221

REPORTING INFORMATION

REFERRAL SOURCE

REFERRED BY		NPI NUMBER
GENETIC COUNSELOR		
INSTITUTION		
TELEPHONE NUMBER	FAX NUMBER	
E-MAIL		
STREET NUMBER	STREET NAME	SUITE NUMBER
CITY	STATE	ZIP

ADDITIONAL REPORTS

REFERRING LAB		REFERRING LAB ID#
CONTACT PERSON		
TELEPHONE NUMBER	FAX NUMBER	
E-MAIL		
STREET NUMBER	STREET NAME	SUITE NUMBER
CITY	STATE	ZIP

ACKNOWLEDGEMENT: I hereby confirm that information has been provided to the patient about the test(s) to be performed and the patient has given consent as required under applicable laws and regulations for the test(s) to be performed. The test(s) to be performed are medically necessary and the results will be used for medical management and treatment decision purposes for this patient. I confirm that the person listed as the Ordering Clinician is authorized by law to order the tests(s) requested herein.

☐ The patient has completed pre-testing genetic counseling.

REQUIRED PROVIDER SIGNATURE X _____ DATE (MM/DD/YYYY) _____

ICD-10 CODES (Required):

CLINICAL DIAGNOSIS:	AGE AT INITIAL PRESENTATION:

TURNAROUND TIME

Heme (Peripheral blood, and bone marrow aspirate)-FISH	3-5 Days
Solid tissue (FFPET)-FISH	5 Days
Heme (Peripheral blood, and bone marrow aspirate)-Chromosome analysis	10-14 Days
Peripheral blood (Constitutional)-Cytogenetics	7 Days
Solid Tumor Oncology - NGS Solid Tumor Panel	10 Days
Solid Tumor Oncology - BRAF V600 Mutation Analysis	7 Days
Hematology Oncology: NGS Myeloid panel	14 Days
Hematology Oncology: FLT3, BCR-ABL, JAK2	4 Days

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CYTOGENETICS

CHROMOSOME MICROARRAY

☐	Congenital postnatal disorders, developmental delay, Autism Spectrum Disorders

CHROMOSOME ANALYSIS

☐	Chromosome analysis for Peripheral blood (Constitutional)
☐	Chromosome analysis for Bone marrow/Leukemic Blood/Tissue (Oncology)

FLUORESCENCE IN SITU HYBRIDIZATION (FISH)

Tests can be ordered as a panel or individually

FISH ONCOLOGY

☐ **MDS Panel**	☐ 5q Deletion (5q31.2)
	☐ 7q Deletion (7q22/7q31.2)
	☐ 20q Deletion(20q12/20q13.1)
	☐ CEP8
	☐ MLL BA (KMT2A) (11q23.3)
☐ **AML Panel**	☐ PML/RARa t(15;17)
	☐ CBFB/MYH11(FDA) inv(16)
	☐ MLL BA(KMT2A) (11q23.3)
	☐ AML1/ETO (RUNX1/RUNX1T1) t(8;21)
☐ **CLL Panel**	☐ MYB (6q23.3)
	☐ IGH/CCND1 t(11;14)
	☐ P53 (17p13)
	☐ ATM (11q22.3)
	☐ CEP12
	☐ 13q Deletion (13q14.2-q14.3/13q34)
☐ **Non-Hodgkin Lymphoma Panel**	☐ IGH BA (14q32.33)
	☐ IGH/BCL2 t(14;18)
	☐ IGH/CCND1 t(11;14)
	☐ BCL6 BA (3q27.3-q28)
	☐ MYC BA (8q24.21)
	☐ MALT1 BA (18q21.31-q21.32)
	☐ ALK
	☐ MYC/IGH
☐ **Non-Hodgkin Lymphoma Panel (High Grade)**	☐ BCL6 BA (3q27.3-q28)
	☐ MYC BA (8q24.21)
	☐ IGH BA (14q32.33)
	☐ BCL2 BA (18q21.33)
	☐ MYC/IGH
	☐ IGH/BCL2
☐ **Non-Hodgkin Lymphoma Panel (Low Grade)**	☐ IGH BA (14q32.33)
	☐ IGH/BCL2 t(14;18)
	☐ IGH/CCND1 t(11;14)
	☐ BCL6 BA (3q27.3-q28)
	☐ MALT1 (18q21.31-q21.32)
☐ **T-Cell lymphoma**	☐ ALK BA (2p23.2-p23.1)
☐ **Chronic Myelogenous Leukemia (CML)**	☐ BCR/ABL1/ASS1 t(9;22)
☐ **Acute Promyelocytic Leukemia (APL)**	☐ PML/RARa t(15;17)
☐ **T-Cell ALL Panel**	☐ TCRAD BA (14q11.2)
☐ **B-Cell ALL Panel**	☐ MLL BA(KMT2A) (11q23.3)
	☐ BCR/ABL1/ASS1 t(9;22)
	☐ CEP4/CEP10/CEP17
	☐ CDKN2A (P16)(9p21)
	☐ ETV6/RUNX1 t(12;21)
	☐ TP53 (17p13)
☐ **Bone marrow Transplant**	☐ SRY (Yp11.31/Yq12/Xp11.1-q11.1)
☐ **Myeloproliferative Disease Panel**	☐ FIP1L1/CHIC2/PDGFRA (4q12)
	☐ PDGFRB BA (5q32)
	☐ FGFR1 BA (8p11.23-p11.22)
	☐ BCR/ABL1/ASS1 t(9;22)

FLUORESCENCE IN SITU HYBRIDIZATION (FISH)

Tests can be ordered as a panel or individually

FISH ONCOLOGY (CONTINUED)

☐ **Plasma Cell Myeloma Panel(CD138 enriched)**	☐ 1p/1q-1q21-q22 /1p32.3
	☐ 5p15/9q22 (NR4A3)/15q22 (SMAD6) Hyperdiploidy
	☐ 13q- -13q14 (RB1) + 13q14 (DLEU) + 13q34 (LAMP)
	☐ FGFR3/IGH- t(4;14) 4p16.3/14q32.33
	☐ CCND3/IGH- t(6;14) 6p21/14q32.33
	☐ IGH/MYEOV- t(11;14) 11q13.3/14q32.33
	☐ IGH/MAFB- t(14;20) 14q32.33/20q12
	☐ CEP17/TP53- 17p13.1/17p11.1-q11.1
	☐ IGH BA
	☒ MYC BA

SOLID TUMOR (FFPET)

☐ **Breast cancer/Gastric cancer**	☐ HER2(ERBB2) (17q12)
☐ **B-Cell Lymphoma**	☐ B- Cell Lymphoma High Grade Panel
	☐ B-Cell Lymphoma Low Grade Panel
	☐ B-Cell Lymphoma NHL Panel

FISH CONSTITUTIONAL

☐ **Constitutional Abnormalities FISH Probes**	☐ DiGeorge/VCFS TUPLE1 Region (22q13.3)
	☐ Williams- Beuren Region (7q11.23)
	☐ SRY (Yp11.31/Yq12/Xp11.1-q11.1)

MOLECULAR ONCOLOGY

SOLID TUMOR ONCOLOGY

☐ **NGS Solid Tumor panel**	Targeted panel for solid tumors, identifying single nucleotide variants, insertion-deletions, copy number variants and gene fusions across 161 genes
☐ **BRAF V600 Mutation Analysis**	BRAF gene analysis; V600E, V600K, V600D

HEMATOLOGY ONCOLOGY

☐ **NGS Myeloid panel**	Targeted panel of all relevant DNA mutations and fusion transcripts associated with myeloid disorders in 40 key DNA target genes and 29 driver genes.
☐ **FLT3-ITD Mutation Analysis**	FLT3 gene analysis of internal tandem repeats (ITD)
☐ **FLT3-TKD Mutation Analysis**	FLT3 gene analysis of tyrosine kinase domain (TKD)
☐ **BCR-ABL p210 Quantitative**	The test measures BCR-ABL1 to ABL1 percent ratio on the International Scale (IS) in t(9;22) positive CML patients. Identifies major breakpoint, p210, fusion transcripts e13a2 and e14a2
☐ **JAK-2 V617F Mutation Analysis**	JAK2 gene mutation analysis, V617F variant

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