

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 health care 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:
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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

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

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

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

FLUORESCENCE IN SITU HYBRIDIZATION (FISH)

Tests can be ordered as a panel or individually

FISH ONCOLOGY (CONTINUED)

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

SOLID TUMOR (FFPET)

<input type="checkbox"/> Breast cancer/Gastric cancer	<input type="checkbox"/> HER2(ERBB2) (17q12)
<input type="checkbox"/> B-Cell Lymphoma	<input type="checkbox"/> B- Cell Lymphoma High Grade Panel <input type="checkbox"/> B-Cell Lymphoma Low Grade Panel <input type="checkbox"/> B-Cell Lymphoma NHL Panel

FISH CONSTITUTIONAL

<input type="checkbox"/> Constitutional Abnormalities FISH Probes	<input type="checkbox"/> DiGeorge/VCFs TUPLE1 Region (22q13.3) <input type="checkbox"/> Williams- Beuren Region (7q11.23) <input type="checkbox"/> SRY (Yp11.31/Yq12/Xp11.1-q11.1)
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MOLECULAR ONCOLOGY

SOLID TUMOR ONCOLOGY

<input type="checkbox"/> NGS Solid Tumor panel	Targeted panel for solid tumors, identifying single nucleotide variants, insertion-deletions, copy number variants and gene fusions across 161 genes
<input type="checkbox"/> BRAF V600 Mutation Analysis	BRAF gene analysis; V600E, V600K, V600D

HEMATOLOGY ONCOLOGY

<input type="checkbox"/> 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.
<input type="checkbox"/> FLT3-ITD Mutation Analysis	FLT3 gene analysis of internal tandem repeats (ITD)
<input type="checkbox"/> FLT3-TKD Mutation Analysis	FLT3 gene analysis of tyrosine kinase domain (TKD)
<input type="checkbox"/> 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
<input type="checkbox"/> JAK-2 V617F Mutation Analysis	JAK2 gene mutation analysis, V617F variant

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