

CLINICAL SPECIMEN INFORMATION

Hosp/Inst where specimen collected: _____
Collection Date _____ Collection Time _____
Specimen ID _____ Block # / Sublabel _____ Tissue Source(s) _____

- Paraffin blocks: Tissue block(s) _____ Cell block(s) _____
 Formalin Bouin's B5 Prefer Michel's (skin IF TM) Other
 Slides: Unstained _____ Stained _____
 Smears: Air-dried _____ Fixed _____ Stained _____
 Blood Bone marrow aspirate Bone marrow core bx Body fluid/CSF
(NOTE: Fresh specimens: EDTA preferred, Heparin ok)
Multiple specimens submitted: Test all Select best block

CLINICAL HX / DX UNDER CONSIDERATION / REQUEST

ICD-9 # _____

- Perform & interpret tests determined medically necessary by PhenoPath MDs
 Perform & interpret only test(s) as requested

PCR MUTATION ANALYSES

- KRAS # PCR0005
 BRAF # PCR0004
 JAK2 # PCR0003
 EGFR # PCR0007

GENE REARRANGEMENT BY PCR

- B cell (IgH) # PCR0001
 T cell (TCR-γ) # PCR0002

FLUORESCENCE IN SITU HYBRIDIZATION (FISH) & CISH

- | | |
|------------------------|--|
| SOLID TUMORS | <input type="checkbox"/> 1p36/19q13 - Oligodendroglioma panel # FISH0013 |
| | <input type="checkbox"/> EGFR/CEP7 # FISH0016 |
| | <input type="checkbox"/> EWSR1 (22q12) translocations (breakapart) # FISH0004 |
| | <input type="checkbox"/> HER2/CEP17 (PathVysion™) # FISH0001 |
| | <input type="checkbox"/> TP53/CEP17 # FISH0024 |
| | <input type="checkbox"/> SMS/RARA # FISH0022 |
| | <input type="checkbox"/> MDM-2/SE12 # FISH0023 |
| | <input type="checkbox"/> SS18 (SYT) translocations (breakapart) # FISH0006 |
| | <input type="checkbox"/> TOP2A/CEP17 # FISH0017 |
| | <input type="checkbox"/> BCL6 (3q27) translocations (breakapart) # FISH0018 |
| LYMPHOMAS | <input type="checkbox"/> IGH (14q32) translocations (breakapart) # FISH0015 |
| | <input type="checkbox"/> MALT1 (18q21) translocations (breakapart) # FISH0007 |
| | <input type="checkbox"/> t(14;18) IGH/MALT1 # FISH0008 |
| | <input type="checkbox"/> t(11;18) MALT1/API2 # FISH0003 |
| | <input type="checkbox"/> MYC panel (FISH0009, FISH0015) # PANL9101 |
| | <input type="checkbox"/> t(4;14) FGFR3/IGH # FISH0020 |
| | <input type="checkbox"/> t(14;16) IGH/MAF # FISH0027 |
| | <input type="checkbox"/> t(11;14) CCND1/IGH # FISH0002 |
| | <input type="checkbox"/> t(14;18) IGH/BCL2 # FISH0005 |
| | <input type="checkbox"/> t(9;22) BCR/ABL # FISH0010 |
| LEUKEMIAS | <input type="checkbox"/> MLL (11q23) translocations (breakapart) # FISH0014 |
| | <input type="checkbox"/> t(15;17) PML/RARA # FISH0011 |
| | <input type="checkbox"/> RARA (17q21) translocations (breakapart) # FISH0019 |
| | <input type="checkbox"/> CLL/SLL panel # PANL9102 |
| | <input type="checkbox"/> Plasma Cell Myeloma FISH Panel (or order individually above):
IGH (# FISH0015) -AND- t(11;14) IGH/CCND1 (# FISH0002)
If IGH is positive and CCND1 is negative, we will run:
t(4;14) IGH/FGFR3 (# FISH0020) -&- t(14;16) IGH/MAF (# FISH0027) |
| OTHER NEOPLASMS | <input type="checkbox"/> Hydatid. Mole Panel (CEP-17 FISH + p53 IHC + MIB IHC) # PANL9105 |
| | <input type="checkbox"/> CEP-X/CEP-Y # FISH0012 |
| | <input type="checkbox"/> EBV (EBER1 mRNA BY ISH) # CISH0001 |
| | <input type="checkbox"/> Other (list): _____ |

MOLECULAR REQUISITION FORM

THIS SECTION FOR PHENOPATH USE ONLY

MOLECULAR

REQUESTING INSTITUTION NAME & ADDRESS

Phone _____ FAX _____

Ordering Pathologist/Physician

Name _____ NPI # _____

PATIENT INFORMATION

Name (Last, First, MI) _____

SSN # _____ DOB _____ Male Female

- Inpatient Outpatient Non-Hospital Patient

Address _____

Phone _____

Medical Record # _____ Pt # _____

TREATING PHYSICIAN

Name _____ NPI # _____

- Mail/Fax add'l copy of report to treating physician
Complete information REQUIRED BELOW

Phone _____ Fax _____

Institution _____

Address _____

City, State Zip _____

**BILLING INFO (Must be provided or Institution will be billed)
Please complete or attach copy of insurance card**

BILL: Ins Medicare Medicaid (WA DSHS only) Institution Pt

Referral/Authorization # _____ **REQUIRED**

Medicare # _____ ICD-9 # _____

Advance Beneficiary Notice Yes (provide copy) No

Healthplan _____

Address _____

Policy/Cert # _____ Group/Plan # _____

Name of Insured _____ Relationship _____

Secondary Insurance Yes (Please attach separate sheet) No

REQUIRED

Person completing form _____

Date _____ Phone _____

Send: REQS: DERM HEME HEMEONC MOL PATH

PhenoBoxes Flow Media (RPMI) IF Media (Michel's)