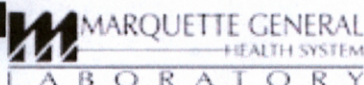


Patient Information:



ONCOLOGY

Laboratory Request Form

Name: Last

420 W. Magnetic Street • Marquette, MI 49855
(906) 225-3050 • 1-888-818-3879

First

M.I.

Phone

Address:

Account Information:

City:

State:

Zip:

Soc. Sec. #

Sex: ☐ M ☐ F

Medicare #:

Retirement date:

Birthdate:

Medical Record #:

Medicaid #:

Please Bill to: ☐ Patient Insurance☐ Account #:

Other / Secondary Insurance

Subscriber's Name:

ID #s:

Clinical Information:

Diagnosis/Clinical Symptoms (ICD-9 format):

Clinical History:

Specimen Information

Specimen Type: ☐ Peripheral Blood ☐ Bone Marrow ☐ Lymph Node ☐ Tissue Biopsy: _____
☐ Touch Prep ☐ Formalin-fixed, paraffin embedded tissue ☐ Other:

Collection Date and Time:

Volume:

Duration:

Treatment Status: ☐ New Diagnosis ☐ Relapse ☐ Monitoring

Test Menu Options

- ☐ **Full Pathology Consultation** - Includes morphology with possible reflex to immunohistochemistry, flow cytometry, chromosome analysis, FISH studies and/or molecular studies as necessary.

Test Requested:

Pathologist/Date:

- ☐ **Individual Test Selection - Only perform the testing selected below.**

☐ **Flow Cytometry****Chromosome Analysis (G-Band)****Individual FISH Assays****Molecular Genetics**☐ **Morphologic Marrow Evaluation**☐ Chromosome Karyotype - Oncology☐ PathVysion HER-2☐ KRAS mutation analysis☐ Chromosome Karyotype - Congenital☐ UroVysion☐ BRAF mutation analysis☐ Add High Resolution Karyotype☐ ALK Rearrangement, NSCLC☐ JAK2 mutation analysis☐ Chromosome Karyotype - Mosaic Study☐ POC Ploidy Determination☐ JAK2, exon 12 mutation☐ **Circulating Tumor Cell Analysis****FISH Panels**☐ BCR/ABL1, t(9;22)☐ FLT3 mutation analysis☐ MDS Panel☐ FIP1L1/PDGFR (4q12 deletion)☐ NPM1 mutation analysis☐ CMPNPanel☐ PDGFRB, t(5;12)☐ KIT mutation analysis☐ AML Panel☐ BCL2/IGH, t(14;18))☐ T Cell Gene Rearrangement☐ CLL/SLL Panel☐ MYC/IGH, t(8;14)☐ CEBPA☐ ALL Panel☐ PML/RARA, t(15;17)☐ Other: _____☐ NHL Panel☐ CCND1/IGH, t(11;14)☐ Myeloma Panel☐ MALT1 Rearrangement, t(11;18)☐ Other: _____**Collection Requirements:**

FLOW: ACD (yellow top) tube

Cytogen: Sodium Heparin (green)

* includes FISH and Chromosome

IHC: EDTA (purple top) tube

PCR: EDTA (purple top) tube

Nurse Practitioner / PA

Physician / Supervising Physician

Date:

Additional Copies of Report To: