Oncology Requisition

ACCOUNT INFORMATION

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Dallas, TX 75230
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CLIA #45D-0659587, CAP #2723201

UT SOUTHWESTERN MEDICAL CENTER
VERIPATH LABORATORIES
www.veripathlabs.com

REQUIRED ORDER INFORMATION

BILL TO: ● Facility / Client ☐ Patient / 3rd party – Billing Information must be provided

Patient Name: (Last, First, Middle)

Mother's Name: (if infant)

Date of Birth: | Sex: | Patient ID / MR#

Hospital Inpatient Y / N | Collection Date: | Collection Time: : AM PM

Ordering Physician (Full Name): | NPI:

Phone: | Pager: | FAX:

Clinical Indication for Tests Ordered:

SPECIMEN INFORMATION

☐ Bone Marrow ☐ Peripheral Blood
☐ Bone Marrow Aspirate Smears ☐ Peripheral Blood Smears
☐ Bone Marrow Touch Prep
☐ Bone Marrow Core Biopsy ☐ Left ☐ Right
☐ Urine ☐ CSF ☐ Body Fluid_____
☐ Tissue: site/type _____
☐ Formalin Fixed Paraffin Embedded Tissue (FFPE)
Case #_____ Block #_____
Signout Pathologist_____

If ordering on non-UT Southwestern Pathology material, please include a copy of the Surgical Pathology/Cytopathology report, the block*/unstained slides and corresponding H&E slide.
*Block is preferred. If sending unstained slides instead, please see next page for instructions.

CLINICAL INFORMATION

Infection: ☐ HIV ☐ Hepatitis ☐ Other _____
History: ☐ Lymphadenopathy ☐ Mediastinal Mass ☐ Splenomegaly
Therapy: ☐ Chemotherapy ☐ Growth Factor ☐ Immunotherapy_____ ☐ Other_____
Status: ☐ Initial ☐ Relapse ☐ Remission ☐ Post Transplant ☐ Other_____

TESTS REQUESTED

Morphology
☐ Bone Marrow Morphology exam ☐ Peripheral Blood exam

Flow Cytometry (ACD preferred) Attach Current CBC Report
☐ Leukemia/Lymphoma Immunophenotyping
☐ PNH (Paroxysmal Nocturnal Hemoglobinuria)
☐ ALPS (Autoimmune Lymphoproliferative Syndrome)
☐ Process and hold - call next day with instructions
☐ Other Markers: _____

Molecular Diagnostics (EDTA preferred)
☐ B-cell Clonality PCR
☐ T-cell Clonality PCR
☐ BCL1/IGH: t(11;14) PCR
☐ BCL2/IGH: t(14;18) PCR (mbr, mcr)
☐ BCR/ABL: t(9;22) quantitative (p210 only) [CML]
WBC Count:_____
☐ BCR/ABL: t(9;22) qualitative (p210, p190) [CML, ALL]
☐ JAK2 V617F mutation analysis PCR
☐ BRAF mutation analysis
☐ KRAS mutation analysis
☐ EGFR mutation analysis
☐ Loss of Heterozygosity (LOH): 1p/19q fragment analysis
☐ IDH1/IDH2 Mutation analysis on brain tumors

PATIENT/3RD PARTY BILLING INFORMATION

ICD-9 Code(s)

Medicare patients with non-covered diagnoses must sign Advanced Beneficiary Notice (ABN) available at www.veripathlabs.com or by calling customer service at 214-645-7057 or toll free 877-887-8136 ☐ Signed ABN included

ICD-9 Codes applicable to each and every test requested should come only from the ordering physician, represent the reason for the test order at the time of order, and be supported by the patient's medical record. Physicians should order only tests that are medically necessary for the diagnosis or treatment of the patient. Tests ordered should be single laboratory tests appropriate for the patient's medical condition. Tests for screening purposes may be ordered, but may not be reimbursed.

Insured/Responsible Party Name: (if different from patient-Last, First, Middle) | Date of Birth:

Patient's relationship: ☐ Self ☐ Spouse ☐ Dependent ☐ Other
Gender: ☐ Male ☐ Female
Responsible Party Address: City
State: Zip: Phone:

Employer's Name: | Employer's Phone:

Insurance Co. Name: | Insurance Co. Phone:

Insurance Co. Address:

Policy #: | Group #:

☐ Medicare ☐ HMO ☐ Other ☐ Medicaid ☐ PPO | Member ID#:

Referral Authorization/Precertification #: | Date/Time:

Name:

TESTS REQUESTED (cont.)

Cytogenetics (Sodium Heparin preferred)
☐ Chromosomal Analysis ☐ FISH specify_____

FISH
☐ ALK: 2p23
☐ BIRC3/MALT1: t(11;18)
☐ BCR/ABL1: t(9;22)
☐ CBFB: inv(16)
☐ CCND1/IGH: t(11;14)
☐ Deletion/monosomy 5
☐ Deletion/monosomy 7
☐ DDIT3: 12q13
☐ EGFR: 7p12
☐ ETV6/RUNX1: t(12;21)
☐ EWSR1: 22q12
☐ FIP1L1/PDGFRA: 4q12
☐ FOXO1: 13q14
☐ HER2/neu
☐ IGH/BCL2: t(14;18)
☐ MLL: 11q23
☐ MYC/IGH: t(8;14)
☐ MYCN: 2q23-24
☐ MYC: 8q24
☐ PML/RARA: t(15;17)
☐ RB1: 13q14
☐ RUNX1T1/RUNX1: t(8;21)
☐ SYT: 18q11.2
☐ TP53: 17p13.1
☐ UroVysion®
☐ Other FISH (please call lab)

FISH Panels: ☐ CLL ☐ MM ☐ MDS ☐ ALL ☐ AML

Transplant Analysis
☐ FISH - X/Y sex chromosomes **Donor Sex:** ☐ Male ☐ Female
☐ STR Pre-transplant analysis ☐ STR Post-transplant analysis
☐ Donor Name:_____ Recipient Name:_____
Please provide dates of all previous transplants:

VERIPATH USE ONLY
Transport Container: Total # of specimens:_____
___Yellow ___Green ___Purple ___Syringe ___Conical ___Red ___Blue ___Cup
___Trans Tube ___Block ___Slides ___Formalin ___Other:_____

Transport Conditions: ☐Frozen ☐Slushy ☐Refrig ☐Room Temp

Destination: ☐Other_____ ☐Coag ☐Cytogen ☐Hemepath ☐Flow ☐Hist ☐Mol Dx

Initials: