Inform Diagnostics Hematology/Oncology Requisition

Initials: _____
HE-0000001

INFORM DIAGNOSTICS

Highlighted fields are required information

PATIENT INFORMATION

Last Name	First Name	MI
Street Address		Apt#
City	State	Zip
Phone	DOB	Sex
Patient MR#		

CLIENT INFORMATION

BILLING INFORMATION

Attach a copy of the patient's demographic sheet, both sides of the patient's insurance card(s) and all secondary insurance information (if applicable).

Attach the Following: • Copy of Recent CBC • Copy of Doctor's Notes/Clinical History

ICD Code(s) Please provide applicable "symptomatic diagnosis" codes _____

Patient Status: ❍ Non-Hospital ❍ Hospital In-Patient ❍ Hospital Out-Patient

PERTINENT INDICATION OR CLINICAL HISTORY Check all that apply

Type of Study: ❑ Initial/Diagnostic ❑ Follow-up/Monitoring ❑ Staging Marrow

❑ Anemia ❑ Leukopenia ❑ Thrombocytopenia ❑ Pancytopenia
❑ Leukocytosis ❑ Erythrocytosis ❑ Thrombocytosis ❑ Neutrophilia
❑ Eosinophilia ❑ Monocytosis ❑ Blasts in Blood ❑ Lymphocytosis
❑ Monoclonal Gammopathy ❑ Other: _____

❑ History of ❑ Rule out

❑ AML ❑ MDS ❑ MPN ❑ CML ❑ B-ALL ❑ T-ALL ❑ CLL/SLL
❑ B-NHL (type) _____ ❑ T-NHL (type) _____
❑ Hodgkin Lymphoma
❑ Hepatosplenomegaly
❑ Bone Lesions ❑ Skin Lesions
❑ Carcinoma (type) _____
❑ Other _____

PRIOR THERAPY OR OTHER RELEVANT CLINICAL INFORMATION Check all that apply

❑ Chemotherapy ❑ Radiation ❑ Rituxan ❑ Other _____
❑ Growth Factor ❑ Campath ❑ Tyrosine Kinase Inhibitor

OTHER APPLICABLE HISTORY/REASON FOR BIOPSY

SPECIMEN INFORMATION Indicate number of tubes, vials, slides or tissue blocks provided

Date of Collection: _____/_____/_____ _____AM _____PM

Bone Marrow Biopsy: Core #_____ Clot #_____ Touch Preparations #_____

Bone Marrow Aspirate: Green-top(s) (Na Heparin) #_____ Purple-top(s) (EDTA) #_____ Smears #_____

Peripheral Blood: Green-top(s) (Na Heparin) #_____ Purple-top(s) (EDTA) #_____ Smears #_____

Tissue Biopsy: Tissue Type/Location _____ ❑ Paraffin Block ❑ Formalin Fixed ❑ Fresh in RPMI ❑ Fresh in Saline Specimen ID# _____

Other (CSF, FNA, Body Fluid, etc. — include location):

COMPREHENSIVE TESTING

❑ **Comprehensive Bone Marrow or Peripheral Blood Diagnostic Analysis*** *Hematopathologist will determine medically appropriate testing based on clinical data and morphologic findings.*

INDIVIDUAL DIAGNOSTIC/PROGNOSTIC TESTS Select individual tests below

Morphology/Microscopic Evaluation
Selected stains will be performed as medically necessary
❑ Morphology Evaluation ❑ Consult

Flow Cytometric Analysis
❑ Leukemia/Lymphoma Panel
❑ ZAP-70 for CLL – Blood Only
❑ PNH Evaluation – Blood Only

Cytogenetic Analysis*
❑ Cytogenetic Analysis Only
❑ Cytogenetic Analysis with reflex to FISH if clinically indicated

Fluorescence In Situ Hybridization (FISH)*
❑ AML ❑ MDS ❑ CML (BCR/ABL) ❑ Eosinophilia ❑ B-ALL ❑ T-ALL
❑ CLL ❑ B-cell NHL ❑ MM ❑ Individual Probes (see reverse)

*Peripheral blood is not an optimal specimen for Cytogenetics or FISH except for CLL and CML.

Molecular Testing (with Interpretation)

CML or B-ALL
❑ Quantitative BCR/ABL (by PCR)
❑ ABL Kinase Domain Mutation (Including T315I) (for patients with known and treated disease only)

Myeloproliferative Neoplasms
❑ MPN Panel (JAK2 V617F reflex to JAK2 Exon 12, CALR and/or MPL W515K/L as medically appropriate.)

AML
❑ AML Prognostic Panel (Known AML Diagnosis Only) (FLT3 and NPM1 with reflex to CEBPA)
❑ Perform IDH1/IDH2 as part of AML Panel

APL Monitoring
❑ Quantitative PML/RARA (48-hour stability)

Mastocytosis
❑ KIT (D816V) Mutation

Lymphoproliferative Disorder
❑ B-Cell Clonality/Gene Rearrangement
❑ T-Cell Clonality/Gene Rearrangement
❑ IGHV Mutation Analysis (CLL)
❑ BCL-1 (Mantle Cell Lymphoma)
❑ MYD88 L265P (Waldenstrom/Lymphoplasmacytic)

Other _____

Contact 855.856.0656 or HemeClientServices@InformDx.com to arrange specimen pickup.
See reverse for optimal specimen requirements and FISH probes.

4207 E. Cotton Center Blvd. / Phoenix, AZ 85040 / 855.856.0656 / Fax: 855.856.0655 / CLIA 03D1064744 / MLS-20-0527.2 3/18

Inform Diagnostics (White) Client Copy (Yellow)

1. Complete all requested information on requisition.
2. Use appropriate number of labels provided.
3. Place one label on each specimen and dispose of the remaining labels.

A1 HE-0000001 Pt. Name _____ DOB ___/___/_____ PB A	B2 HE-0000001 Pt. Name _____ DOB ___/___/_____ PB A	C3 HE-0000001 Pt. Name _____ DOB ___/___/_____ PB A	D4 HE-0000001 Pt. Name _____ DOB ___/___/_____ PB A	E5 HE-0000001 Pt. Name _____ DOB ___/___/_____ PB A
F6 HE-0000001 Pt. Name _____ DOB ___/___/_____ PB A	G7 HE-0000001 Pt. Name _____ DOB ___/___/_____ PB A	H8 HE-0000001 Pt. Name _____ DOB ___/___/_____ PB A	I9 HE-0000001 Pt. Name _____ DOB ___/___/_____ PB A	J10 HE-0000001 Pt. Name _____ DOB ___/___/_____ PB A

Please discard extra labels

Inform Diagnostics **Hematology/Oncology Requisition**

INFORM DIAGNOSTICS

Hematology/Oncology Optimal Specimen Requirements

The matrix below indicates the optimal specimens required for testing. Please include as many specimens as possible for each technology. For a complete and timely analysis, please include all recommended specimen types.

TEST/TECHNOLOGY	BONE MARROW CORE	BONE MARROW CLOT	BONE MARROW ASPIRATE	PERIPHERAL BLOOD	PERIPHERAL BLOOD SMEAR	LYMPH NODES/ FRESH TISSUE	FIXED TISSUE (PARAFFIN BLOCK W/H&E)	FLUIDS	STORAGE & TRANSPORT
Comprehensive Bone Marrow Analysis	Place in 10% formalin	Place in 10% formalin	2–3 ml in green-top (sodium heparin) tube **AND** 0.5–1.0 ml in purple-top (EDTA) tube	2–3 ml in purple-top (EDTA) tube and CBC (a CBC will be performed if not submitted)	2 freshly prepared smears preferred				Store at room temperature. Use **FROZEN** cold pack for transport.
Comprehensive Bone Marrow Analysis (Dry Tap)	One (1) core in formalin and one (1) core in **RPMI** †			2–3 ml in green-top (sodium heparin) tube **AND** 2–3 ml in purple-top (EDTA) tube	2 freshly prepared smears preferred				Store at room temperature. Use **FROZEN** cold pack for transport.
Comprehensive Peripheral Blood Analysis				2–3 ml in green-top (sodium heparin) tube **AND** 2–3 ml in purple-top (EDTA) tube	2 freshly prepared smears preferred				Store at room temperature. Use **FROZEN** cold pack for transport.
Morphology	At least four (4) touch preparations (air-dried). Place core in 10% formalin	Place in 10% formalin	4–5 freshly prepared smears preferred **and** 1 ml aspirate in purple-top (EDTA)	2–3 ml in purple-top (EDTA) tube and CBC (a CBC will be performed if not submitted)	2 freshly prepared smears	Place in 10% formalin	Representative paraffin block		Store at room temperature. Use **FROZEN** cold pack for transport.
Flow Cytometry			2–3 ml in purple-top (EDTA) tube preferred	2–3 ml in purple-top (EDTA) tube preferred		Representative tissue in RPMI †		Representative fluid	Store at room temperature. Use **FROZEN** cold pack for transport.
ZAP-70 for CLL or PNH Evaluation				2–3 ml in purple-top (EDTA) tube preferred					Store at room temperature. Use **FROZEN** cold pack for transport.
Immunohistochemistry (IHC)	Place in 10% formalin	Representative paraffin block				Place in 10% formalin	Representative paraffin block		Store at room temperature. Use **FROZEN** cold pack for transport.
Cytogenetics - Karyotype			2–3 ml in green-top (sodium heparin) tube	2–3 ml in green-top (sodium heparin) tube *Peripheral blood is not an optimal specimen for Cytogenetics except for CLL and CML*					Store at room temperature. Use **FROZEN** cold pack for transport.
Fluorescence in situ Hybridization (FISH)			3 ml in green-top (sodium heparin) preferred or purple-top (EDTA) tube	3 ml in green-top (sodium heparin) preferred or purple-top (EDTA) tube* *Peripheral blood is not an optimal specimen for FISH except for CLL and CML*					Store at room temperature. Use **FROZEN** cold pack for transport.
Molecular (PCR, Sequencing)			2–3 ml in purple-top (EDTA) tube	2–3 ml in purple-top (EDTA) tube			Representative paraffin block		Store at room temperature. Use **FROZEN** cold pack for transport.

† **DO NOT** use RPMI if it is cloudy, yellow or is at or beyond expiration date. Use only pink/orange RPMI. If RPMI is not available, use saline.

FISH: The panels are designed to detect the most common abnormalities for a given disease group. Additional probes may be added to further characterize abnormalities found in the primary panel(s). Peripheral blood is not an optimal specimen for Cytogenetics or FISH except for CLL and CML.

B-ALL PBX1/TCF3[t(1;19)] CEP 4 p16 (9p21)/CEP9 CEP 10 BCR/ABL t(9;22) MLL (11q23) TEL/AML1 t(12;21)	**T-ALL** 9p21/CEP 9 BCR/ABL [t(9;22)] MLL (11q23) p53 (17p13.1)	**AML** RPN1/MECOM inv(3)/t(3;3) ETO (RUNX1T1)/ AML1(RUNX1) t(8;21) MLL (11q23) PML/RARA t(15;17) CBFB inv(16)/t(16;16)	**CLL** MYB (6q23.3) ATM (11q22.3) CCND1/IgH t (11;14) CEP 12 D13S319 (13q14.3) p53 (17p13.1)	**CML** BCR/ABL t(9;22)	**Eosinophilia** PDGFRA/FIP1L1 (4q12) PDGFRB (5q32-q33) FGFR1 (8p12)
MDS RPN1/MECOM inv(3)/t(3;3) EGR1 (5q31) D7S522 (7q31) CEP 8 MLL (11q23) RB1 (13q14.2) D20S108 (20q12)	**MM** CKS1B/CDKN2C (1q21/1p32.3) FGFR3/IgH t(4;14) CEP 7 CEP 9 CCND1/IgH t(11;14) RB1 (13q14.2) IgH/MAF (14;16) p53 (17p13.1)	**B-cell NHL** BCL6 (3q27) c-MYC (8q24) CCND1/IgH t(11;14) IgH/BCL2 t(14;18) MALT1 (18q21) *Bone marrow aspirate and FFPE are acceptable specimen types.*	**Anaplastic Large Cell Lymphoma** ALK (2p23) **Follicular Lymphoma** IgH/BCL2 t(14;18)	**Burkitt Lymphoma** c-MYC (8q24) **Mantle Cell Lymphoma** CCND1/IgH t(11;14)	**Additional Available Probes** (Undecalcified Formalin-Fixed Tissues Only) Her2/CEP17 ROS1 Melanoma (CCND1, RREB1, MYB/CEP6, RREB1/CEP6, CDKN2A/CEP9) Glioblastoma (1pq/19pq)

‡Inform Diagnostics medical staff will select the number and type of antibodies, other reagents or probes that are necessary. In keeping with the requirements of Medicaid and Medicare, it is the policy of Inform Diagnostics to only perform testing that is medically necessary for the diagnosis and treatment of the patient. Medicare does NOT pay for routine screening tests.

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