University of Michigan Health System

Cytogenetics Requisition and Clinical History Form

MLabs
Department of Pathology
SP 2F367 UH, SPC 5054
1500 E. Medical Center Drive
Ann Arbor, MI 48109-5054
734-936-2598
800-862-7284

Birthdate	Sex M F
Patient Name Last First MI	
Client Code **8999**	Patient Registration or Medical Record Number
Location Code **REFR**	Ordering Doctor/DR#

Collection Date: ____/____/_____ | Collection Time: AM PM | ☐ Send Copy of report to Physician: Dr. First/Last Name: _____

Patient Address | City | State | ZIP Code | Home Phone # ( ) -

Policy Holders Name:	Primary Insurance (Card Name):	Primary Policy/Contract #:	Primary Group #:	Policy Holders DOB:
Policy Holders Name:	Secondary Insurance (Card Name):	Secondary Policy/Contract #:	Secondary Group #:	Policy Holders DOB:

ICD-9 Codes are required for billing. A partial list is provided on the back of this requisition. | **ICD-9 Codes** | | | | | |

FOR ALL INSURANCE & MEDICARE PATIENTS

I understand that Medicare or my private insurance carrier may not pay for tests that it determines are not reasonable or necessary for my diagnosis. If Medicare or my private insurance carrier denies payment, I agree to be personally responsible for the entire payment. I also authorize any holder of medical, demographic or billing information about me to release it to my insurance carrier for purposes of determining payment of medical insurance benefits.

Patient Signature: _____

Specimen Type

- ☐ Peripheral Blood
- ☐ Bone Marrow Aspirate
- ☐ Bone Marrow Biopsy/Bone Core
- ☐ Lymph Node
- ☐ Other:_____
- ☐ Skin Biopsy, Source: _____
- ☐ Fetal/Stillbirth ----------> LMP _____
- ☐ Products of Conception (POC) ----> Gest. Age: _____
- ☐ Placenta ----------> GA by LMP or U/S? _____

The following must be completed before testing is performed

Suspected diagnosis/indication/reason for ordering Cytogenetics:

CONSTITUTIONAL/GENETICS:

- ☐ Chromosome Analysis (Routine Karyotype)

FISH for Microdeletion Syndromes (select below)

- ☐ DiGeorge/VCF (22q11.2)
- ☐ Prader-Willi (15q11.2)
- ☐ Angelman (15q11.2)
- ☐ Smith-Magenis (17p11.2)
- ☐ Miller-Dieker (17p13.3)
- ☐ Williams (7q11.23)
- ☐ Microduplication of 15q11-q13
- ☐ Other: _____

FISH testing is performed as an adjunct to Chromosome Analysis when appropriate (using the specimen submitted for Chromosome Analysis). Please contact the MLabs Client Services Center prior to collecting specimen to request "stand alone" FISH testing.

MALIGNANCY:

- ☐ Chromosome Analysis (Karyotype)

FISH with Oncology Probes (select below)

- ☐ BCR/ABL (for post-Gleevec testing only)
- ☐ Other: _____

DISEASE STATUS:

- ☐ Initial specimen (pretreatment)
- ☐ Known to be complete remission
- ☐ Possible remission
- ☐ Known to have residual disease
- ☐ Known to have disease in relapse
- ☐ CML: ☐ Chronic phase ☐ Accelerating ☐ Acute phase ☐ Remission

Proven BCR/ABL positive by:

☐ RT-PCR ☐ FISH ☐ Chromosomes

Previous karyotype results: _____

- ☐ If suspected secondary malignancy:

Primary malignancy: _____

Treatment (RT, CT, etc): _____ Date: _____

- ☐ **Previous Cytogenetics results:** _____

TREATMENT HISTORY:

Patient's current medications: _____

Types of therapy received to date for current disease:

☐ None ☐ Radiotherapy ☐ Chemotherapy

☐ Gleevec ☐ Other (indicate drug): _____

Please note: Additional testing and/or charges may be associated with Cytogenetic testing. Please refer to the MLabs Handbook