



Dept of Pathology & Laboratory Medicine
 2401 Gillham Rd
 Kansas City, MO 64108
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Oncology
Cytogenetics Requisition
[CMH Website Resources](#)

Patient's Name: Last		First	Middle	Birthdate	Gender
Address			City, State, Zip	Phone	
Client/Practice Name		Address		City, State, Zip	Phone
Ordering Provider		Clinician Signature			Fax
ICD 10 (Diagnosis)		MEDICAL NECESSITY REGULATIONS: at the government's request, the Lab would like to remind all physicians that when ordering tests expected to be paid under federal health care programs, such as Medicare and Medicaid, the testing must meet the following conditions: (1) included as covered services, (2) reasonable, (3) medically necessary for the treatment and diagnosis of the patient and (4) not for screening purposes.			
Billing: <input type="checkbox"/> Self-pay <input type="checkbox"/> Insurance - Attach copy of card (both side)		Patient is: <input type="checkbox"/> Child <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other (specify)			
Subscriber: Last, First, MI		Primary: carrier & policy number			
Employer		Secondary: carrier & policy number			
Insurance Authorization <input type="checkbox"/> Not required or Authorization Number: _____ Valid Date(s): _____					

By submitting this requisition, the ordering physician attests:

- All requested laboratory tests are medically necessary
- Insurance preauthorization has been obtained if required by the payor**

If numeric diagnosis code(s) and an authorization number are not provided as appropriate, the laboratory reserves the right to refuse service.

Specimen Information			STAT	Results
Collection Date:	Time: AM/PM	Collected by:	<input type="checkbox"/>	Physician:
For best results, send specimen same day as collection. If necessary to hold specimen overnight, keep at room temp – DO NOT FREEZE.				Call results to:
Diagnosis/Indication				Fax results to:
Test(s) Requested: <input type="checkbox"/> Chromosome Analysis <input type="checkbox"/> Microarray Analysis Copy Number + SNP <input type="checkbox"/> STR Chimerism <input type="checkbox"/> FISH as necessary to clarify diagnosis <input type="checkbox"/> STR Chimerism, cell sorted: <input type="checkbox"/> FISH, specify _____ <input type="checkbox"/> CD3+ <input type="checkbox"/> CD19+ <input type="checkbox"/> CD33+ <input type="checkbox"/> CD56+ <input type="checkbox"/> Diagnostic <input type="checkbox"/> Follow Up Bone Marrow Transplant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Specimen(s) submitted: <input type="checkbox"/> Same sex <input type="checkbox"/> Opposite sex <input type="checkbox"/> Bone Marrow <input type="checkbox"/> Neoplastic Blood <i>submit CBC and WBC differential with specimen</i> <input type="checkbox"/> FFPE scrolls for Microarray <input type="checkbox"/> Peripheral Blood for constitutional study – <i>constitutional vs. clonal</i> <input type="checkbox"/> Solid Tumor _____ <input type="checkbox"/> DNA for STA (must be isolated in a CLIA or equivalent lab) <input type="checkbox"/> Other _____				

SPECIMEN REQUIREMENTS:

Blood: Chromosome Analysis – Sodium Heparin (green); Microarray – EDTA (lavender)
 Bone Marrow: 3-4 mL
 Neoplastic Blood: 5-10 mL
 Solid Tumor: 0.5 – 1.0 cm³ *deliver to laboratory ASAP*
 FFPE scrolls: 5 scrolls (10 microns thick in 1.5 mL tube)
 Sorted Cells (CD3+, CD19+, CD33+, CD56+): 8 mL blood or bone marrow in EDTA lavender