

**CLIENT IDENTIFICATION** **PATIENT IDENTIFICATION**

	<b>Last Name</b>		<b>First Name</b>		<b>Middle Initial</b>
	Address		City	State	ZIP
	<b>DOB</b>	Age	<b>Gender</b> M / F	SSN	Phone
	<b>Ordering Physician</b> _____			MRN _____	
Treating Physician _____			<b>Specimen ID</b> _____		

<b>INSURANCE INFORMATION</b>		<input type="checkbox"/> Attached face sheet/insurance    Primary Ins: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other    Secondary Ins: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
<input type="checkbox"/> Medicare # _____	<input type="checkbox"/> Medicaid # _____	<input type="checkbox"/> Pre-Authorization # _____	
<input type="checkbox"/> Primary Ins.    INSURER    POLICY #    GROUP #		<input type="checkbox"/> Secondary Ins.    INSURER    POLICY #    GROUP #	
		<b>BILLING INFORMATION</b>	
		Bill to: <input type="checkbox"/> Client <input type="checkbox"/> Insurance <input type="checkbox"/> Patient	

**DIAGNOSIS INFORMATION** PLEASE PROVIDE CBC

ICD-10 Code(s): \_\_\_\_\_  
(ICD-10 information is required)

Physician Notice: Only tests or diagnostic services that are medically necessary should be ordered. Appropriate ICD-10 information must be provided in the specified area above. Payers, including Medicare and Medicaid, generally do not pay for screening tests. ABN is required for Medicare patients if ICD-10 codes provided do not support reasoning for testing.

New Diagnosis     Post-Therapy     Relapse     Remission  
 Previous Cytogenetics/FISH:  Normal  Abnormal (Please Provide Report)  
 Allogeneic Bone Marrow Transplant    Donor Sex:  Male  Female

<b>SPECIMEN INFORMATION</b>		Hospital status when specimen collected:	
Two unique identifiers are required on requisition & specimen		<input type="checkbox"/> Hospital Inpatient <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Non-Hospital Outreach/Clinic Patient	
<input type="checkbox"/> Bone Marrow Asp    # ___ Na-Heparin    # ___ EDTA    # ___ Other <input type="checkbox"/> Blood    # ___ Na-Heparin    # ___ EDTA    # ___ Other <input type="checkbox"/> Smears    # ___ Air-Dried    # ___ Fixed    # ___ Stained <input type="checkbox"/> Slides    # ___ Stained    # ___ Unstained    # ___ Touch Preps <input type="checkbox"/> Tissue <input type="checkbox"/> FNA <input type="checkbox"/> Body Fluid (specify type) _____ <input type="checkbox"/> Paraffin Block(s)    # ___ <input type="checkbox"/> Pick best block		Collection Date _____ Time _____ Date of Discharge _____ <input type="checkbox"/> ABN is available Date Pulled from Archive _____ Body Site _____ <input type="checkbox"/> Formalin Fixed _____ <input type="checkbox"/> Other Fixation _____ Cold Ischemia Time (min) _____    Fixation Time (hours) _____	

**LABORATORY TESTS REQUESTED** (specimen requirements on back)

**NEXT GENERATION SEQUENCING**

(All NGS tests will be client billed. Client bill authorization required prior to testing.)

**Hematology Profile**

Complete Hematology Profile - 177 Genes (full list of genes on back)  
 Profile of molecular abnormalities in numerous hematologic neoplasms including

- Acute Myeloid Leukemia
- Myelodysplasia Profile
- Myeloproliferative Neoplasms
- Lymphoma

**Solid Tumor Profile**

Complete Solid Tumor Profile w/TMB - 434 Genes (full list of genes on back)  
 Profile of molecular abnormalities in numerous solid tumors including

- Lung
- Breast
- Colorectal
- Brain
- Gastrointestinal

**Solid Tumor Fusion Expression Profile**

Solid Fusion Expression Profile - 60+ Genes (full list of genes on back)  
 Designed to detect various translocations including ALK, ROS1, RET, NTRK1, NTRK2, NTRK3, BRAF, CIC, EWSR1, PD-L1, and more. This assay also aids in sarcoma diagnosis and classification.

**Hematology Liquid Biopsy**

Hematology cfDNA Liquid Biopsy Profile - 177 Genes (full list of genes on back)

**MOLECULAR ASSAYS**

UnitedHealthcare commercial plan patients are required to have a prior authorization for molecular testing. Please include PA number in billing section above.

FLT3

Reflexes: If FLT3 and cytogenetic results are normal, reflex to NPM1+CEBPA Panel

If FLT3+ with monocytic differentiation, reflex to NPM1

If NPM1+ & FLT3-, reflex to IDH1/IDH2

If inv(16) or t(8;21), reflex to KIT exons 8, 17

IDH1+IDH2 (with NPM1 Mutation - HEME)     IDH1+IDH2 (GBM)     KIT (D816V)

BCR-ABL1 Screening p190+p210 (No previous results on file at CSI)

BCR-ABL1 Follow-up: (select  p190 or  p210)     ABL1 Kinase Domain Mutation

PML-RARA     BRAF (HCL)

JAK2 V617F     JAK2 reflex Exon 12     JAK2 reflex CALR, MPL     IgVH (CLL/SLL)

Bcell (IGH reflex to IGK)     Tcell (Gamma reflex to Beta)     IGH-BCL2     MYD88

**Solid Tumor**

KIT (GIST)     KIT reflex PDGFRA (GIST)     KIT (Melanoma)

MSI (Normal + Tumor) PCR     MGMT Methylation

EGFR w/T790M (Lung)     ALK FISH     ROS1 FISH     EGFR T790M reflex ALK+ROS1

KRAS     BRAF     NRAS     KRAS reflex BRAF+NRAS     Other \_\_\_\_\_

**Solid Tumor Panels**

Lung Panel (PD-L1 - IHC, BRAF, EGFR w/T790M reflex to ALK+ROS1 - FISH)

Colorectal Carcinoma Panel (KRAS, NRAS, BRAF, MMRP by IHC)

Additional Tests, Comments, or Differential Diagnosis

Authorized Signature \_\_\_\_\_ Phone Number for STAT Cases: \_\_\_\_\_