

Molecular Oncology Lab

Phone: 800-245-3117 x6162 | Fax 414-937-6206



NOTE: Versiti does NOT bill patients or insurance. Test orders must be placed through a medical facility that has an account with Versiti. Client # required.

Ordering Institution Information			
Person Completing Requisition:		Physician/Provider:	
Institution:		Client #:	
Dept:		Address:	
City:		State:	Zip Code:
Phone (Lab):		Provider Contact (phone/email):	
Special Reporting Requests:		PO #:	
Is testing for outpatient Medicare enrollee or Wisconsin Medicaid recipient? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please complete the beneficiary form located at https://versiti.org/products-services/requisitions and submit with this requisition.			
Patient Information			
Last Name:		First Name:	MI: DOB:
MR#:	Accession #:		SSN:
Biologic Sex/Sex Assigned at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other		Ethnicity: <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Ashkenazi Jewish <input type="checkbox"/> Other _____	
Specimen Information			
Specimen Type: <input type="checkbox"/> EDTA WB <input type="checkbox"/> EDTA Bone Marrow <input type="checkbox"/> Frozen Total RNA <input type="checkbox"/> Other _____		Draw Date:	Draw Time:
Patient History			
Diagnosis: _____			
Is this for disease monitoring?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Has the BCR-ABL1 fusion been previously detected in this patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please state method: _____	
White blood cell count: _____			
Testing			
<input type="checkbox"/> BCR-ABL Quantitative Analysis (4502) <input type="checkbox"/> BCR-ABL Quantitative Analysis (4502) and BCR-ABL Breakpoint Identification (4504)			

VERSITI USE ONLY	
____ EDTA WB ____ EDTA BM ____ Frozen Total RNA ____ Other: _____	
Opened By:	Reviewed By:
Evaluated By:	Labeled By:

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DRAWING INSTRUCTIONS

Tubes must be individually labeled with **FULL NAME OF INDIVIDUAL, ANOTHER IDENTIFIER (e.g., SSN, MRN, DOB), DATE AND TIME OF DRAWING.** Samples cannot be accepted after any exposure to an environment in which HLA genes are amplified. This precaution is essential to avoid contamination of samples with DNA that could alter test results. **Samples will be accepted from 8:00 a.m. Monday through noon on Friday.** Emergency testing **MUST** be arranged through the laboratory. Call (414) 937-6201.

TEST	SAMPLE REQUIREMENTS	STORE and SHIP
BCR-ABL Quantitative Analysis	10 mL EDTA (lavender top) whole blood OR 3-5 mL bone marrow aspirate	Room temperature via an overnight courier. Samples must be received within 48 hours of being drawn.

Verification of Informed Consent

It is recommended that healthcare providers obtain a signed informed consent from the patient when genetic testing is ordered. By signing the informed consent, the patient agrees that that they have received and understand the indications and implications of the genetic test and are voluntarily agreeing to have the test performed. In some states, informed consent is required by existing laws and regulations. Versiti recommends that ordering healthcare providers verify their state laws and regulations regarding informed consent for genetic testing. An informed consent form may be available from your institution, or one can be found at <http://www.versiti.org/hg> under Forms & Materials. Information regarding a general description of the test, purpose, sensitivity, analytical limitations, and the features and genetics of the condition(s) is also available in the Versiti test catalog.

New York State patients: New York state healthcare providers are required to provide verification that informed consent (complying with New York State Department of Health Genetic Testing Standard 5 [GT S5] and New York State Civil Rights Law, Section 79-l) has been obtained from their patient. For genetic testing to be performed in our laboratory, please sign the verification below or submit a signed informed consent form. The sample will be destroyed not more than 60 days after the sample was obtained, unless a longer period of retention is expressly authorized in the consent.

Verification of Informed Consent: I am a healthcare provider for the patient named on this requisition. I have obtained the required informed consent from the patient or the patient’s legal guardian for each genetic test(s) ordered above and I authorize the testing of the enclosed specimen(s). I understand that no tests other than those authorized will be performed on genetic samples.

Signature of healthcare provider _____

Date _____

SHIPPING INFORMATION

Contact laboratory for pediatric drawing requirements or low white cell count drawing requirements. Blood samples should be shipped by overnight carrier. The package must be shipped in compliance with carrier's guidelines. Please contact your carrier for current biohazardous shipping regulations.

Label Box: Refrigerate, Room Temperature, or Frozen (whichever is appropriate)

Packages should be addressed to:

Versiti Wisconsin – Molecular Oncology Laboratory
638 N 18th Street
Milwaukee, WI 53233