Versiti does NOT bill patients or their insurance. Call 800-245-3117 ext. 6250 for your Client#.

Person Completing Requisition:	
Institution:	Client#:
Dept:	Physician:
Address:	
City:	ST: ZIP:
Phone(Lab):	Phone (Physician):

MOLECULAR ONCOLOGY LAB
Phone 800-245-3117 x6162
Fax 414-937-6206

Patient/Sample Name	Last		First		MI		
MR #		Accession #		**SSN**	- -		
DOB	/ /	Gender	☐ M ☐ F	Ethnicity	☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Ashkenazi Jewish ☐ Other		
Specimen Type	☐ Blood ☐ DNA ☐ Bone Marrow ☐ Buccal Swab accepted, please call Client Services prior to sending					Draw Date	/ /
Anticoagulant	☐ EDTA ☐ ACDA ☐ ACDB ☐ Citrate ☐ Sodium Heparin ☐ Other					Draw Time	
Special Reporting Requests:						**PO#:**	

Medicare

Is testing for outpatient Medicare enrollee or Wisconsin Medicaid recipient? **Yes ☐ No ☐**

If yes, please complete our beneficiary form located at www.versiti.org/medical-professionals/products-services/requisitions and submit with this requisition.

Patient History

☐ **Acute Myeloid Leukemia (AML)**
- ☐ With history of previous therapy
- ☐ With history of prior MDS
- ☐ With Down syndrome
- ☐ With recurrent genetic abnormality

☐ **Myelodysplastic Syndrome (MDS)**

Please state sub-classification of MDS: _____

☐ **Myeloproliferative Neoplasm (MPN)**
- ☐ Chronic Myelogenous Leukemia (CML)
- ☐ Polycythemia Vera (PV)
- ☐ Essential Thrombocythemia (ET)
- ☐ Primary Myelofibrosis (PMF)

☐ **Other Diagnosis:** _____

Is this an initial diagnosis of AML / MDS / MPN?	☐Yes	☐No	
Is this testing for a relapsed disease?	☐Yes	☐No	If yes, please state original diagnosis: _____
Is this testing to examine for residual disease?	☐Yes	☐No	If yes, please state original diagnosis: _____
Has there been any prior molecular genetic testing?	☐Yes	☐No	If yes, please state previous results:

Tumor Cell Percentage | % Neoplastic Cells: _____

Complete Blood Count

Hemoglobin: _____ White blood cell count: _____ Absolute monocyte count: _____ Absolute lymphocyte count: _____ Platelet count: _____

Peripheral blood smear: ☐ Normal ☐ Abnormal If abnormal, please describe: _____

Bone Marrow Biopsy

Pathologic Diagnosis: _____ Provide cytogenetic / FISH results if available: _____

Please indicate all tests required

Companion Diagnostics (CDx)

- ☐ 4675 **LeukoStrat® CDx FLT3 Mutation Assay**
- ☐ 7647 **IDH1 Abbott RealTime PCR**
- ☐ 7648 **IDH2 Abbott RealTime PCR**

Acute Myeloid Leukemia (AML)

- ☐ 4675 **LeukoStrat® CDx FLT3 Mutation Assay**
- ☐ 4629 **CEBPA Mutation Analysis**
- ☐ 4636 **NPM1 Mutation Analysis**
- ☐ 4637 **NPM1 Mutation Analysis (CEBPA Reflex)**
- ☐ 7635 **DNMT3A Exon 23 Sequence Analysis**
- ☐ 7647 **IDH1 Abbott RealTime PCR**
- ☐ 7648 **IDH2 Abbott RealTime PCR**
- ☐ 4646 **IDH1 & IDH2 Mutation Detection**
- ☐ 4647 **IDH1 Exon 4 Mutation Detection**
- ☐ 4648 **IDH2 Exon 4 Mutation Detection**
- ☐ 4645 **RUNX1 Sequence Analysis - Somatic**
- ☐ 4638 **KIT Exon 8 and 17 Mutation Analysis**
- ☐ 4657 **TP53 Exons 2-11 Mutation Analysis**
- ☐ 4662 **ASXL1 Mutation Analysis**

Chronic Myeloid Leukemia (CML)

- ☐ 4502 **BCR-ABL Quantitative Analysis**
- ☐ 4504 **BCR-ABL Breakpoint Identification** (Order with BCR-ABL Quantitative Analysis)
- ☐ 4507 **BCR-ABL Kinase Mutation Analysis**

Myeloproliferative Neoplasms (MPN)

- ☐ 4621 **MPN Reflex (PV)** (JAK2 V617F, reflex to JAK2 Exon 12)
- ☐ 4644 **MPN Reflex(ET/PMF)** (JAK2 V617F, reflex to CALR, reflex to MPL Exon 10)
- ☐ 4617 **JAK2 V617F Mutation Analysis**
- ☐ 4618 **JAK2 Exon 12 Mutation Analysis**
- ☐ 7630 **CALR Mutation Analysis**
- ☐ 4642 **MPL Exon 10 Mutation Analysis**
- ☐ 4662 **ASXL1 Mutation Analysis**

Systemic Mastocytosis

- ☐ 4750 **KIT D816 Mutation Analysis**

Versiti Use Only	
___EDTA ___BM	Opened By____
___Amnio ___Heparin	Evaluated By____
___ACDA ___CVS	Reviewed By____
___Other_____	Labeled By____

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DRAWING INSTRUCTIONS: Tubes must be individually labeled with **FULL NAME OF INDIVIDUAL, DOB, and DATE & TIME OF DRAW**. **Samples will be accepted from 8:00 A.M. to 5:00 P.M. Monday through Friday and Saturday morning (see notes below).** Emergency testing **MUST** be arranged through the laboratory by calling 1-800-245-3117, ext. 6162.

Test	Sample Type	Store and Ship
LeukoStrat® CDx FLT3 Mutation Assay	• 2 mL Na Heparin (green top) whole blood; **OR** • 0.5 mL Na Heparin bone marrow **Refrigerate (2-8°C) samples after collection before shipping.**	Ship on cold packs (2-8°C) via an overnight courier. **Samples must be received within 7 days of being drawn.**
IDH1 or IDH2 Abbott RealTi*m*e PCR NOTE: One tube is adequate if ordering both tests	• 3-5 mL EDTA (lavender top) whole blood; **OR** • 2-5 mL EDTA bone marrow aspirate **Refrigerate (2-8°C) samples after collection before shipping.**	Ship on cold packs (2-8°C) via an overnight courier. **Samples must be received within 7 days of being drawn.**
ASXL1, CALR, CEBPA, DNMT3A, IDH1, IDH2, JAK2 Exon 12, JAK2 V617F, KIT D816, KIT Exons 8 & 17, MPL Exon 10, MPN Reflex, NPM1, RUNX1, TP53	• 3-5 mL EDTA (lavender top) whole blood; **OR** • 2-5 mL EDTA bone marrow aspirate;**OR** • High Quality DNA ≥ 500 ng at 25ng/ul	Room temperature.
BCR-ABL Quantitative Analysis BCR-ABL Kinase Mutation Analysis	• 10 mL EDTA (lavender top) whole blood; **OR** • 3-5 mL EDTA bone marrow aspirate	Room temperature via an overnight courier. **Samples must be received within 48 hours of being drawn.**

Blood samples should be shipped by overnight courier. The package must be shipped in compliance with carrier's guidelines. Please contact your carrier for current biohazardous shipping regulations.

Packages should be addressed to: **Versiti Wisconsin – Molecular Oncology Laboratory**
638 North 18th Street
Milwaukee, WI 53233

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

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.* 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. In order 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