



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

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

Patient/Sample Name	Last			First			MI
MR #				Accession #			SSN
DOB	/	/	Gender	<input type="checkbox"/> M <input type="checkbox"/> F	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 Type	<input type="checkbox"/> Blood <input type="checkbox"/> DNA <input type="checkbox"/> Bone Marrow <input type="checkbox"/> Buccal Swab accepted, please call Client Services prior to sending					Draw Date	/ /
Anticoagulant	<input type="checkbox"/> EDTA <input type="checkbox"/> ACDA <input type="checkbox"/> ACDB <input type="checkbox"/> Citrate <input type="checkbox"/> Sodium Heparin <input type="checkbox"/> 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

<input type="checkbox"/> Acute Myeloid Leukemia (AML)	<input type="checkbox"/> Myeloproliferative Neoplasm (MPN)
<input type="checkbox"/> With history of previous therapy <input type="checkbox"/> With history of prior MDS <input type="checkbox"/> With Down syndrome <input type="checkbox"/> With recurrent genetic abnormality	<input type="checkbox"/> Chronic Myelogenous Leukemia (CML) <input type="checkbox"/> Polycythemia Vera (PV) <input type="checkbox"/> Essential Thrombocythemia (ET) <input type="checkbox"/> Primary Myelofibrosis (PMF)
<input type="checkbox"/> Myelodysplastic Syndrome (MDS)	<input type="checkbox"/> Other Diagnosis: _____
Please state sub-classification of MDS: _____	
Is this an initial diagnosis of AML / MDS / MPN?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is this testing for a relapsed disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please state original diagnosis: _____
Is this testing to examine for residual disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please state original diagnosis: _____
Has there been any prior molecular genetic testing?	<input type="checkbox"/> Yes <input type="checkbox"/> 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

Chronic Myeloid Leukemia (CML)

- 4502 BCR-ABL Quantitative Analysis
- 4504 BCR-ABL Breakpoint Identification (Order with BCR-ABL Quantitative 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

Versiti Use Only		
EDTA	BM	Opened By _____
Amnio	Heparin	Evaluated By _____
ACDA	CVS	Reviewed By _____
Other		Labeled By _____

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

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	<ul style="list-style-type: none"> • 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 RealTime PCR NOTE: One tube is adequate if ordering both tests	<ul style="list-style-type: none"> • 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.
CALR, JAK2 Exon 12, JAK2 V617F, MPL Exon 10, MPN Reflex	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 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