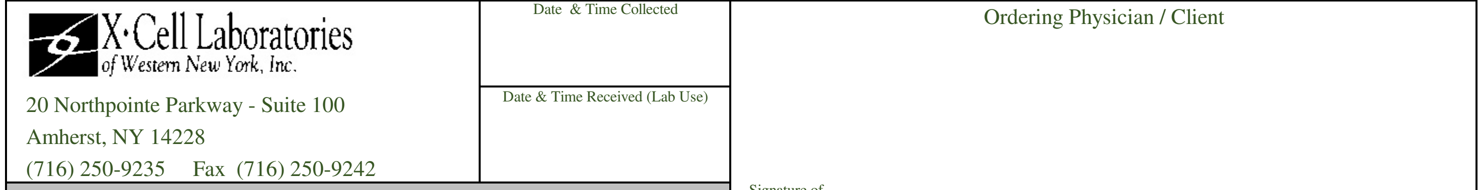
CYTOGENETICS TESTING SERVICES REQUISITION

The space above this line is for laboratory use only.



X·Cell Laboratories of Western New York, Inc.

20 Northpointe Parkway - Suite 100
Amherst, NY 14228
(716) 250-9235 Fax (716) 250-9242

Date & Time Collected

Date & Time Received (Lab Use)

Ordering Physician / Client

Signature of Requesting Physician (Required) ____________________

Patient Name	Last	First
Address		
City State Zip		

D.O.B.		Sex		Phone	

ICD-10 Code (Mandatory)	ICD-10 Code	ICD-10 Code	ICD-10 Code

COPY OF REPORT TO: (**FAX NUMBER MUST BE PROVIDED**)

NAME	FAX #
NAME	FAX #

Please label all specimens with the patient's full name. Provide patient's clinical history and other relevant information as appropriate. This is a requirement of the NYSDOH.

BILLING

☐ Insurance ☐ Patient ☐ Client

PRIMARY INSURANCE INFORMATION

Insurance Company	
Contract/ID/Policy #	Group #
Name of Insured	

SECONDARY INSURANCE INFORMATION

Insurance Company	
Contract/ID/Policy #	Group #
Name of Insured	

Relevant Clinical History

Type Of Specimen

☐ Peripheral Blood* ☐ Bone Marrow* WBC count:

*** Please send a copy of the most recent CBC and differential**

☐ Tissue Site: Fixation time:

Ischemic time:
(Required for breast and gastric cx)

Testing Requested

Chromosome Analysis (Karyotype): ☐ **Cancer cytogenetics** ☐ **Constitutional cytogenetics •**

• For NYS patients, informed consent is required for non-oncology cytogenetics testing. Please complete back of requisition.

FISH for Hematopoietic Disorders:

Chronic Lymphocytic Leukemia

☐ CLL Panel (ATM, +12, del (13q), TP53, IGH/CCND1)

** Specimen type: Bone marrow or peripheral blood*

Chronic Myeloid Leukemia/ Myeloproliferative Neoplasms

☐ BCR/ABL1 t(9;22)

** Specimen type: Bone marrow or peripheral blood*

Plasma Cell Neoplasms

☐ Multiple Myeloma Panel (CKS1B/CDKN2C, del(13q)/-13, TP53, +3, +7, +9, +15, IGH, reflex to IGH/CCND1, IGH/FGFR3, IGH/MAF, IGH/MAFB)

** Specimen type: Bone marrow*

Myelodysplastic Syndrome/Acute Myeloid Leukemia

☐ MDS Panel (EVI1, del(5q)/-5, del(7q)/-7, +8, MLL, del(20q)/-20)
☐ AML Panel (RUNX1/RUNX1T1, CBFB/MYH11, PML/RARA, BCR/ABL1, del(13q), TP53, EVI1, del(5q)/-5, del(7q)/-7, +8, MLL, del(20q)/-20)
☐ RUNX1/RUNX1T1 t(8;21)
☐ CBFB/MYH11 inv(16) or t(16;16)
☐ PML/RARA t(15;17)

** Specimen type: Bone marrow or peripheral blood*

High Grade B-cell Lymphoma

☐ HGBCL Panel (MYC, BCL2, BCL6)
☐ MYC
☐ BCL2
☐ BCL6

** Specimen type: FFPE*

Follicular Lymphoma

☐ IGH/BCL2 t(14;18)

** Specimen type: Bone marrow or peripheral blood or FFPE*

Mantle Cell Lymphoma

☐ IGH/CCND1 t(11;14)

** Specimen type: Bone marrow or Peripheral blood*

FISH for Solid Tumor:

Breast Cancer

☐ HER2/neu

Gastric Cancer

☐ HER2/neu

Lung Adenocarcinoma

☐ ALK
☐ ROS1

Lipomatous neoplasms

☐ MDM2

Additional Instructions:

Please refer to the back of requisition for important information about Genetic Testing