

Person Completing Requisition		
Client	Client#	
Department	Phone	
Address		
City	ST	ZIP
Physician		



MOLECULAR DIAGNOSTICS LAB
 Phone 800-245-3117 x 6218
 Fax (414) 937-6202

Patient/Sample Name					
Last		First		MI	
MR #	Accession #		SS #	-	-
DOB mm/dd/yyyy	/	/	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"/> Bone Marrow <input type="checkbox"/> Plasma <input type="checkbox"/> Serum <input type="checkbox"/> Amniotic Fluid <input type="checkbox"/> CVS <input type="checkbox"/> Cultured Amniotic Fluid <input type="checkbox"/> Cultured CVS <input type="checkbox"/> Buccal Swab <input type="checkbox"/> DNA <input type="checkbox"/> Other			Draw Date	mm/dd/yyyy / /
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"/> Clot <input type="checkbox"/> Other			Draw Time	

Indicate Special Reporting/Billing Requests **BloodCenter of Wisconsin does not bill patients or their insurance.**

PO# _____

Is testing for outpatient Medicare enrollee or Wisconsin Medicaid recipient? Yes No If yes, please complete information on reverse.

TEST ORDERS

Patient Diagnosis _____

CANCER TESTING

PURPOSE OF TESTING: Diagnosis Monitoring Therapy

AML

- AML Mutation Panel with reflex to CEBPA if FLT3 and NPM1 negative (4627)
- AML Mutation Panel (FLT3 and NPM1 mutations)(4619)
- AML Familial Evaluation (4639)
- CEBPA Mutation Analysis (4629)
- FLT3 Mutation Analysis (4635)
- KIT Exons 8 and 17 Mutation Analysis (4638)
- NPM1 Mutation Analysis (4636)

MPD

- BCR-ABL Quantitative Analysis (4502)
- BCR-ABL Breakpoint Identification-order with BCR-ABL Quant.
- BCR-ABL Kinase Mutation Analysis (4507)
- JAK2 V617F Mutation Analysis (4617)
- JAK2 Exon 12 Mutation Analysis (4618)
- MPL W505/S515N Mutation Analysis (5759)

Lymphoma

- Non Hodgkin's Lymphoma (BCL-2) (4510)

ENGRAFTMENT / CHIMERISM TESTING

TRANSPLANT INFORMATION:

- Bone Marrow Liver Small Bowel Other _____

Transplant Date: _____

Donor Name: _____

Sample Information-Pre-transplant Work-up

- Pre-Transplant Analysis (Recipient) (4020)
- Donor Analysis (4040) (provide recipient name)

Recipient Name: _____

Sample Information-Post Transplant Testing

- Chimerism on blood or bone marrow (4199)
- Prepare CD3 & CD33 cells, perform chimerism (4091/4199)
- Prepare CD3 cells, perform chimerism (4093/4199)
- Prepare MNC, perform chimerism (4092/4199)
- Prepare Buffy Coat, perform chimerism (4094/4199)

- STAT Testing (Results in 48 hours / 72 hours if CD3/CD33.)

- Twin Zygosity Analysis (4060/4070)

Complete for Prenatal Genotyping Cases:

LMP Date: _____ Gestational Age: _____

Sample(s) submitted from (check all that apply):

The analysis of parental samples is highly recommended.

- Mother Father No Parental Sample

Father's Name: _____

Father's DOB: _____

RED CELL GENOTYPING (check appropriate system and complete serological information if known)

Indication for testing: Hemolytic Disease of the Newborn

- Transfused Patient Other _____

- | | |
|--|---|
| <input type="checkbox"/> Do ^{ab} (Dombrock)(4375) | <input type="checkbox"/> M (4435) |
| <input type="checkbox"/> Fy ^{ab} (Duffy) (4405) | <input type="checkbox"/> Rh C/c (4445) |
| <input type="checkbox"/> Jk ^{ab} (Kidd) (4425) | <input type="checkbox"/> Rh D (4455) |
| <input type="checkbox"/> Js ^{ab} (KEL6/7)(4385) | <input type="checkbox"/> Rh D Zygosity (4475) |
| <input type="checkbox"/> K1/K2 (Kell) (4415) | <input type="checkbox"/> Rh E/e (4465) |
| <input type="checkbox"/> Lu ^{ab} (Lutheran)(4395) | <input type="checkbox"/> Ss (4485) |

Maternal / Patient serological type _____

Paternal serological type _____

PLATELET AND NEUTROPHIL ANTIGEN GENOTYPING

Please complete a Platelet And Neutrophil Immunology Lab Requisition

GENETIC TESTING (please attach pedigree, if appropriate)

Indication for testing: Carrier Diagnosis Prenatal

- Factor VIII Gene Inversion (4620)
- Hemochromatosis (4600)
- Hemoglobin SC Mutation Analysis (4624)

OTHER: _____

BCW Use Only		
_____ EDTA	_____ BM	Opened By _____
_____ Amnio	_____ Heparin	Evaluated By _____
_____ CD3	_____ CD33	Reviewed By _____
_____ ACDA	_____ C1P	Labeled By _____
_____ Other _____		

DRAWING INSTRUCTIONS: Tubes must be individually labeled with **FULL NAME OF INDIVIDUAL, DATE AND TIME OF DRAW. Samples will be accepted from 8:00 A.M. to 5:00 P.M. Monday through Friday and Saturday morning.** Emergency testing **MUST** be arranged through the laboratory by calling 1-800-245-3117, ext. 6218.

Test	Sample Type	Ship
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.
Non-Hodgkin's Lymphoma JAK2 V617F , JAK2 Exon 12, MPL W505/S515N, AML Mutation Panel, CEBPA or FLT3, NPM1, KIT Exons 8 and 17, AML Familial	3-5 mL EDTA (lavender top) whole blood OR 2-5 mL EDTA bone marrow aspirate DNA, high quality, ≥ 500 ng at 25 ng/ul	Room temperature.
Genotyping Hemoglobin SC Mutation Red Cell Antigen RhD Zygosity	FETAL: 7-15 mL amniotic fluid or cultured amniotic cells (2x10 ⁶ cells minimum) (backup culture highly recommended) 5-10 mg CVS with maternal tissue dissected or 2-T25 flasks cultured CVS(backup culture highly recommended) PARENTAL: 3-5 mL EDTA whole blood (lavender top)	Room temperature.
Engraftment / Chimerism	PRE-TRANSPLANT: 3-5 mL EDTA (lavender top) whole blood or bone marrow OR 4-8 Buccal Swabs POST-TRANSPLANT: 3-5 mL EDTA (lavender top) whole blood or bone marrow	Room temperature.
CD3/CD33 Enrichment	14 mL Na Heparin (green top) whole blood.	Room temperature. Samples must be received within 24 hours of draw and may be drawn Monday through Thursday.
Hemochromatosis Factor VIII Inversion	3-5 mL EDTA (lavender top) whole blood	Room temperature.
Tissue	50-150 mg tissue – call lab prior to shipping	Freeze and ship on dry ice or place in transport media and ship on ice or cold pack

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.

Packages should be addressed to:

**Client Services/Molecular Diagnostics Laboratory
BloodCenter of Wisconsin
638 North 18th Street
Milwaukee, WI 53233**

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

Verification of Informed Consent for **New York State** Patients. (A more extensive informed consent form is available upon request.)

No tests other than those authorized will be performed on genetic samples. The sample will be destroyed not more than sixty days after the sample was taken, unless a longer period of retention is expressly authorized in the consent.

Physician I am a physician counseling the patient named on the front side of this requisition. I have obtained the informed consent of the patient for each genetic test(s) ordered above and authorize the testing of the enclosed specimen(s).

Signature of Physician _____

Date _____

Patient I have been informed of the nature and limitations of each genetic test requested on this form and give my permission to the above named physician to send my specimen(s) to BloodCenter of Wisconsin for testing. I authorize BloodCenter of Wisconsin to report the results to the above named physician or a designated diagnostic center.

Name of diagnostic center: _____

Signature of Patient _____

Date _____

MEDICARE (OUTPATIENT) AND MEDICAID BILLING INFORMATION

BloodCenter of Wisconsin will bill the institution unless testing is performed on an outpatient Medicare enrollee or a Medicaid recipient from WI.

Medicare # _____

Railroad Retiree # _____

Medicaid # _____

(Wisconsin only)

Patient's Address _____

City _____

State _____

Zip _____

Diagnosis _____

ICD9 Dx Code _____

Referring Physician's Full Name _____

Referring Physician's Provider # _____

(UPIN # and NPI #)

Physician's Phone Number _____