



UNIVERSITY OF CONNECTICUT HEALTH CENTER
 Division of Human Genetics
 Genetics Laboratory, Butler Building 5
 263 Farmington Avenue
 Farmington, Connecticut 06030-6140
 LABORATORY 860-679-2469 LAB FAX 860-679-3616

LAB USE ONLY	
Date Received	____/____/____
Lab Number:	_____

Laboratory Request Form for Oncology Study Human Genetics Laboratories

Patient	Specimen
Name: _____ Last First	<input type="checkbox"/> Bone Marrow <input type="checkbox"/> Slides/paraffin blocks <input type="checkbox"/> Blood <input type="checkbox"/> Other _____ <input type="checkbox"/> Tumor tissue (please call in advance)
Address: _____ _____	
DOB: ____/____/____ Sex: _____	
UConn T00#: _____ Adm #: _____	
Date / Time Collected _____ Date / Time Received _____	

Clinical Information	
<input type="checkbox"/> New Diagnosis <input type="checkbox"/> Relapse <input type="checkbox"/> Remission <input type="checkbox"/> Patient has had BM transplant Sex of Donor: _____ Current Therapy (Regimen and Date): _____ _____ Blood WBC count _____ % Blasts _____ <div style="border: 1px solid black; padding: 2px; text-align: center; margin-top: 10px;">Solid Tumor</div> Type _____ Other: Specify _____	<div style="border: 1px solid black; padding: 2px; text-align: center; margin-bottom: 10px;">Non-Lymphocytic</div> <input type="checkbox"/> CML <input type="checkbox"/> Other myeloproliferative, Type _____ <input type="checkbox"/> ANLL M _____, Secondary _____ <input type="checkbox"/> Erythroleukemia <input type="checkbox"/> MDS, Type _____ <div style="border: 1px solid black; padding: 2px; text-align: center; margin-top: 10px;">Lymphocytic</div> <input type="checkbox"/> B <input type="checkbox"/> T <input type="checkbox"/> ALL L _____ <input type="checkbox"/> CLL <input type="checkbox"/> Plasma cell, Type _____ <input type="checkbox"/> Lymphocytosis <input type="checkbox"/> NHL, specify _____ <input type="checkbox"/> Hodgkins lymphoma

Referring Physician
Name: _____ Phone: _____ Fax: _____ Dept. and Hospital: _____

Requesting Tests	
<input type="checkbox"/> CHROMOSOME STUDY (Green-top tubes for Cytogenetics) <div style="border: 1px solid black; padding: 2px; text-align: center; margin-top: 5px;">FISH (Green or Purple-top tubes)</div> <input type="checkbox"/> t(9;22)(BCR/ABL) [CML,ALL] <input type="checkbox"/> t(8;21)(AML1/ETO) [AML-M2] <input type="checkbox"/> t(15;17)(PML/RARA) [AML-M3] <input type="checkbox"/> Inv(16)(CBFB/MYH11) [AML-M4] <input type="checkbox"/> 11q23 (MLL) rearrangements <input type="checkbox"/> -5 or del(5q) [MDS, AML] <input type="checkbox"/> -7 or del(7q) [MDS, AML] <input type="checkbox"/> del(20q) [MPD, MDS] <input type="checkbox"/> Trisomy 8 [Myeloid] <input type="checkbox"/> MDS panel <input type="checkbox"/> 8q24 (MYC) rearrangement [Burkitt's] <input type="checkbox"/> t(11;14)(CCND1/IGH) [Mantle Cell Lym.] <input type="checkbox"/> t(14;18)(BCL2/IGH) [Follicular Lym.] <input type="checkbox"/> Trisomy 12 [CLL] <input type="checkbox"/> Rb deletion [-13 or del(13q)] [Lymphoid] <input type="checkbox"/> P53 deletion [del(17p)] [Lymphoid] <input type="checkbox"/> CLL panel <input type="checkbox"/> Multiple Myeloma panel <input type="checkbox"/> Her2/neu amplification in breast cancer <input type="checkbox"/> Other _____	<input type="checkbox"/> PCR (Purple or Yellow-top tubes) <input type="checkbox"/> BCR/ABL [CML, ALL] <input type="checkbox"/> Qualitative <input type="checkbox"/> Quantitative <input type="checkbox"/> AML1/ETO [AML-M2] <input type="checkbox"/> PML/RARA [AML-M3] <input type="checkbox"/> CBFB/MYH11 [AML-M4] <input type="checkbox"/> JAK2 mutation [MPD] <input type="checkbox"/> MLL/AF4 [ALL] <input type="checkbox"/> E2A/PBX1 [t(1;19)] [ALL] <input type="checkbox"/> B cell clonality [Lymphoma] <input type="checkbox"/> T cell clonality [Lymphoma] <input type="checkbox"/> BCL2/IGH [t(14;18)] <input type="checkbox"/> TEL/AML1 [t(12;21)] [ALL] <input type="checkbox"/> Other _____

For Lab Use Only:	Billing Codes:	<input type="checkbox"/> 004 Biopsy Set-up <input type="checkbox"/> 015 Bone Marrow <input type="checkbox"/> 019 Cyto Study (blood) <input type="checkbox"/> 050 No Growth <input type="checkbox"/> 999 Misc. \$ _____ desc. _____ Billed on: ____/____/____ Report Sent on: ____/____/____	Ind Code: _____ ICD-9: _____
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