

Cancer Cytogenetics Requisition

INPATIENT

Floor/Room# _____



Yale Cytogenetics Laboratory

Department of Genetics

WWW335, 333 Cedar Street

New Haven, CT 06510

Phone: 203-785-2146 Fax: 203-785-7342

<http://medicine.yale.edu/labs/cytogenetics/>

Bone Marrow Samples MUST be in **Sodium Heparin**

Patient Identification or Place sticker here		
Patient Name (Last, First)	Location	
MRN# _____	DOB _____ / ____ / ____	Sex _____ M / F

For cytogenetic lab use only <input type="checkbox"/> NPS <input type="checkbox"/> Prev Abnl <input type="checkbox"/> Prev NL	
Lab #:	
Date/Time:	
Tech Initial:	

Specimen Information	
<input type="checkbox"/> Bone Marrow <input type="checkbox"/> Leukemic Blood _____ % Blasts <input type="checkbox"/> Lymph Node <input type="checkbox"/> Solid Tumor: Site/Type _____ <input type="checkbox"/> Tissue Biopsy, specify: _____	Date Specimen Collected: _____ <input type="checkbox"/> New Diagnosis <input type="checkbox"/> Relapse <input type="checkbox"/> Remission S/P transplant: Y / N Donor: autologous / M / F Check if patient has or may have: <input type="checkbox"/> AIDS <input type="checkbox"/> Hepatitis <input type="checkbox"/> EB Virus

Clinical Information	
Clinical Diagnosis (lymphocytic leukemias and lymphomas, please indicate if B or T cell): <input type="checkbox"/> ALL, pre-B <input type="checkbox"/> CLL <input type="checkbox"/> Multiple Myeloma / MGUS <input type="checkbox"/> ALL, B-cell <input type="checkbox"/> CML <input type="checkbox"/> Myeloproliferative disorder * <input type="checkbox"/> ALL, T-cell <input type="checkbox"/> Cytopenia* <input type="checkbox"/> Myelodysplastic disorder* <input type="checkbox"/> AML <input type="checkbox"/> Lymphoma* <input type="checkbox"/> Other	ICD9 Code: _____
*Specify Type / Additional History _____	

Test Requested

<input type="checkbox"/> Karyotype (G-band Chromosome Analysis)		
<input type="checkbox"/> Fluorescence In Situ Hybridization (FISH) - specify below		
ALL (B-cell) <input type="checkbox"/> <i>B-ALL panel</i> <input type="checkbox"/> ABL/BCR, t(9;22) <input type="checkbox"/> MLL, t(11q23;v) <input type="checkbox"/> TEL/AML1, t(12;21) <input type="checkbox"/> CEP4/10/17, Hyperdiploidy <input type="checkbox"/> IGH, t(14q32;v) <input type="checkbox"/> cMYC, t(8q24;v) <input type="checkbox"/> p16, 9p- <input type="checkbox"/> p53, 17p- <input type="checkbox"/> E2A/PBX1, t(1;19) ALL (T-cell) <input type="checkbox"/> <i>T-ALL panel</i> <input type="checkbox"/> TCRA/D, t(14q11;v) <input type="checkbox"/> TCRB, t(7q35;v) <input type="checkbox"/> p16, 9p- MPD <input type="checkbox"/> <i>MPD panel</i> <input type="checkbox"/> FIPIL1/PDGFR, t(4q12;v) <input type="checkbox"/> PDGFRB, t(5q33;v)	CLL <input type="checkbox"/> <i>CLL panel</i> <input type="checkbox"/> DLEU1/CEP12, 13q/+12 <input type="checkbox"/> ATM/p53, 11q-/17p- <input type="checkbox"/> IGH, t(14q32;v) <input type="checkbox"/> cMYC/MYB, +8q/6q- <input type="checkbox"/> BCL6, 3q amplification Lymphoma <input type="checkbox"/> <i>Lymphoma panel</i> <input type="checkbox"/> IGH, t(14q32;v) <input type="checkbox"/> cMYC, t(8q24;v), Burkitts <input type="checkbox"/> BCL6, t(3q27;v) <input type="checkbox"/> MALT, t(18q21;v) <input type="checkbox"/> ALK, t(2p23;v) <input type="checkbox"/> CCND1/IGH, t(11;14), Mantle cell <input type="checkbox"/> IGH/BCL2, t(14;18), Follicular MGUS/MM <input type="checkbox"/> <i>Myeloma panel</i> <input type="checkbox"/> IGH, t(14q32;v) <input type="checkbox"/> 15q/17p, Hyperdiploidy <input type="checkbox"/> DLEU1, 13q-	MDS <input type="checkbox"/> <i>MDS panel</i> <input type="checkbox"/> EGR1, 5q-/5 <input type="checkbox"/> RELN/TES, 7q-/7 <input type="checkbox"/> cMYC/D20S108, +8/20q- AML <input type="checkbox"/> <i>AML panel</i> <input type="checkbox"/> ABL/BCR, t(9;22) <input type="checkbox"/> MLL, t(11q23;v) <input type="checkbox"/> ETO/AML1, t(8;21) <input type="checkbox"/> CBF, inv(16) <input type="checkbox"/> PML/RARA, t(15;17), STAT CML <input type="checkbox"/> ABL/BCR, t(9;22) Sex-mismatched BMT/SCT <input type="checkbox"/> XX/XY <input type="checkbox"/> Other, specify: _____

Genomic Microarray Analysis (Array CGH) **contact lab prior to ordering**

Referring Physicians (information required for reporting)	
MD: _____	MD: _____
Address: _____	Address: _____
Phone: _____	Phone: _____
Fax: _____	Fax: _____

Consent for Testing _____
<p style="font-size: small;">I hereby authorize Yale Cytogenetics Lab to perform the selected test(s) on this patient, as well as any additional FISH test(s) deemed clinically necessary. I also authorize the lab to preserve for scientific or teaching purposes or otherwise dispose of any residual sample material not needed for diagnosis.</p>