Cancer Cytogenetics Requisition

OUTPATIENT

Bone Marrow Samples MUST be in Sodium Heparin

Yale Cytogenetics Laboratory
Department of Genetics
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http://medicine.yale.edu/labs/cytogenetics/

Patient Identification or Place sticker here

Patient Name (Last, First) **Location**

MRN# **DOB** **Sex**

/ / M / F

For cytogenetic lab use only ☐NPS ☐Prev Abnl ☐Prev NL

Lab #:

Date/Time:

Tech Initial:

Specimen Information

☐ **Bone Marrow**
☐ **Leukemic Blood** _____**% Blasts**
☐ **Lymph Node**
☐ **Solid Tumor:** Site/Type _____
☐ **Tissue Biopsy, specify:** _____

Date Specimen Collected: _____
☐ New Diagnosis ☐ Relapse ☐ Remission
S/P transplant: Y / N **Donor:** autologous / M / F
Check if patient has or may have:
☐ AIDS ☐ Hepatitis ☐ EB Virus

Clinical Information

Clinical Diagnosis (lymphocytic leukemias and lymphomas, please indicate if B or T cell):

☐ ALL, pre-B ☐ CLL ☐ Multiple Myeloma / MGUS
☐ ALL, B-cell ☐ CML ☐ Myeloproliferative disorder *
☐ ALL, T-cell ☐ Cytopenia* ☐ Myelodysplastic disorder*
☐ AML ☐ Lymphoma* ☐ Other

*Specify Type / Additional History _____

ICD9 Code:

Test Requested

☐ **Karyotype (G-band Chromosome Analysis)**

☐ **FISH (specify below)**

ALL (B-cell)
☐ *B-ALL panel*
- ☐ ABL/BCR, t(9;22)
- ☐ MLL, t(11q23;v)
- ☐ TEL/AML1, t(12;21)
- ☐ CEP4/10/17, Hyperdiploidy

☐ IGH, t(14q32;v)
☐ cMYC, t(8q24;v)
☐ p16, 9p-
☐ p53, 17p-
☐ E2A/PBX1, t(1;19)

ALL (T-cell)
☐ *T-ALL panel*
- ☐ TCRA/D, t(14q11;v)
- ☐ TCRB, t(7q35;v)

☐ p16, 9p-

MPD
☐ *MPD panel*
- ☐ FIPIL1/PDGFRA, t(4q12;v)
- ☐ PDGFRB, t(5q33;v)

CLL
☐ *CLL panel*
- ☐ DLEU1/CEP12, 13q-/+12
- ☐ ATM/p53, 11q-/17p-
- ☐ IGH, t(14q32;v)
- ☐ cMYC/MYB, +8q/6q-

☐ BCL6, 3q amplification

Lymphoma
☐ *Lymphoma panel*
- ☐ IGH, t(14q32;v)
- ☐ cMYC, t(8q24;v), Burkitts
- ☐ BCL6, t(3q27;v)
- ☐ MALT, t(18q21;v)
- ☐ ALK, t(2p23;v)

☐ CCND1/IGH, t(11;14), Mantle cell
☐ IGH/BCL2, t(14;18), Follicular

MGUS/MM
☐ *Myeloma panel*
- ☐ IGH, t(14q32;v)
- ☐ CEP 6/15/17, Hyperdiploidy
- ☐ DLEU1, 13q-

MDS
☐ *MDS panel*
- ☐ EGR1, 5q-/-5
- ☐ RELN/TES, 7q-/-7
- ☐ cMYC/D20S108, +8/20q-

AML
☐ *AML panel*
- ☐ ABL/BCR, t(9;22)
- ☐ MLL, t(11q23;v)
- ☐ ETO/AML1, t(8;21)

☐ CBFB, inv(16)
☐ PML/RARA, t(15;17), STAT

CML
☐ ABL/BCR, t(9;22)

Sex-mismatched BMT/SCT
☐ XX/XY

☐ 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 _____

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.