Colorado Genetics Laboratory
www.coloradogeneticslab.com

PRENATAL / PREGNANCY LOSS / POSTNATAL
TEST REQUEST FORM

Revised hŎůžōŜ 201y

12705 E. Montview Blvd., Suite 400
Aurora, Colorado 80045
(303) 724-5701
(888) 659-4932 Toll Free
(303) 724-5795 Fax

PATIENT INFORMATION

Patient Last Name ☐ First Name ☐ Middle Initial ☐ Sex: M ☐ F ☐

Date of Birth ☐ Hospital/ID # ☐ INPATIENT ☐ OUTPATIENT ☐

REFERRED BY

PHYSICIAN ☐
Address ☐
Phone ☐ FAX ☐
Email ☐

FACILITY ☐
Address ☐
Phone ☐ FAX ☐

BILLING

Bill charges to: Patient ☐ Insurance* ☐ Hospital ☐ Physician/Clinic ☐ **Attach billing information*

Include signed waiver if microarray requested

SIGNS, SYMPTOMS, DIAGNOSIS, AND ICD10 CODES — REQUIRED FOR SPECIMEN PROCESSING (PLEASE DO NOT USE "RULE OUT")

In addition to the studies requested below, I authorize the laboratory to perform FISH (fluorescence *in situ* hybridization) if indicated by the patient's clinical history or cytogenetic results.

SPECIMEN INFORMATION — STUDIES REQUESTED

Date Collected ☐ Time ☐ AM ☐ PM ☐ Amount Collected ☐

PRENATAL

Gestation by U/S ☐
LMP ☐
G ☐ P ☐ SAB ☐ TAB ☐
Fetal Sex (*if known*): M ☐ F ☐

- ☐ Amniotic Fluid
  Alpha-fetoprotein (reflex to AChE)? Yes ☐ ***No*** ☐
- ☐ Chorionic villus
- ☐ Percutaneous umbilical blood
- ☐ Other (*specify*): ☐

CHROMOSOMES:

- ☐ Standard chromosome analysis
- ☐ Standard chromosome analysis; **IF NORMAL → REFLEX to SNP microarray** (*on cultured cells*)

FISH:

- ☐ STAT trisomy screen by FISH & standard chromosome analysis
- ☐ STAT trisomy screen by FISH; **IF ABNORMAL → REFLEX** to standard chromosome analysis
  IF NORMAL → REFLEX to SNP microarray** & 5-cell chromosome analysis
- ☐ FISH for (specify): ☐ & standard chromosome analysis

MICROARRAY:

- ☐ Chromosomal SNP microarray** & standard chromosome analysis
- ☐ Chromosomal SNP microarray** & 5-cell chromosome analysis

***** If inadequate direct sample, microarray may be performed on cultured cells.***

PREGNANCY LOSS

Gestation ☐
Fetal Sex (*if known*): M ☐ F ☐

- ☐ Products of conception
- ☐ Placenta
- ☐ Fetal tissue (*specify*): ☐
- ☐ Other (*specify*): ☐

CHROMOSOMES:

- ☐ Standard chromosome analysis
- ☐ Standard chromosome analysis; **IF NORMAL → REFLEX to SNP microarray** (*on cultured cells*)
- ☐ Standard chromosome analysis**; IF CULTURE FAILURE → REFLEX** to pregnancy loss trisomy screen by FISH

FISH:

- ☐ Pregnancy loss trisomy screen by FISH on paraffin embedded tissue
- ☐ FISH for (specify): ☐ & standard chromosome analysis

MICROARRAY:

- ☐ Chromosomal SNP microarray
- ☐ Chromosomal SNP microarray & 5-cell chromosome analysis

POSTNATAL

- ☐ Peripheral blood
- ☐ Cord blood
- ☐ Skin Biopsy
- ☐ Saliva - Spit
- ☐ Saliva - *Buccal/Mouth Swab*
- ☐ Other (*specify*): ☐

Is sample parental/familial follow-up for an abnormal microarray? Yes ☐

Child's name: ☐

DOB: ☐

CHROMOSOMES:

- ☐ Standard chromosome analysis
- ☐ High resolution chromosome analysis

FISH:

- ☐ STAT trisomy screen by FISH & standard chromosome analysis
- ☐ FISH for (*specify*): ☐ & standard chromosome analysis (*if not previously performed*)

MICROARRAY:

- ☐ Chromosomal SNP microarray
- ☐ Chromosomal SNP microarray & 5-cell chromosome analysis
- ☐ CIYʹMIʹf ¢IʹNƎŜűŜŘ / a ! - ***Contact Laboratory if patient not initially studied by CGL***

PATIENT LABEL HERE

ADDITIONAL SERVICES

(*Indicate sample above*)

- ☐ Culture for molecular or biochemical studies
- ☐ Culture and freeze

→ ***Include Information for Referral Specimens form, signed waiver, and payment for shipping***

Microarray consent, specimen requirements, information for referral specimens, and waiver forms all available online.

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CANCER
TEST REQUEST FORM

Revised June 2018

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Physician/Authorized Signature:

SPECIMEN COLLECTION

Date Collected | Time | AM ☐ PM ☐ | Amount Collected

SPECIMEN INFORMATION

- ☐ Bone marrow aspirate
- ☐ Bone marrow core biopsy
- ☐ Solid tumor (source):
- ☐ Other (specify):
- ☐ Peripheral blood
- ☐ Lymph node
- ☐ FFPE slides (4 micron on Plus Slides) (source):

- ☐ CML
- ☐ AML
- ☐ ALL
- ☐ Myeloma
- ☐ Myelodysplasia
- ☐ B-cell lymphoma
- ☐ T-cell lymphoma
- ☐ CLL
- ☐ Other:

Transplant Information
Is the patient post transplant? Yes ☐ If Yes, sex of donor: M ☐ F ☐

STUDIES REQUESTED

☐ **Chromosome analysis**

☐ **FISH Studies for:**

- ☐ BCR/ABL1 t(9;22)
- ☐ Chimerism (for BMT patients)
- ☐ EGFR
- ☐ IGH (BAP)
- ☐ KMT2A (MLL)(11q23)
- ☐ MECOM (EVI1)
- ☐ PML/RARA t(15;17)
- ☐ PTEN
- ☐ TP53 (17p13.1)
- ☐ 1p36/1q25 deletion
- ☐ 19q13 / 19p13 deletion
- ☐ Screen for prior abnormal clone
- ☐ Other (specify):

- ☐ ALL Panel
- ☐ AML Panel
- ☐ AML Panel plus PML/RARA
- ☐ Eosinophilia Panel
- ☐ MDS Panel
- ☐ MPN Panel
- ☐ Myeloma panel
- ☐ Myeloma panel plus Reflex MYC; IGH/MYC

- ☐ Initial CLL Panel (ATM; 12; 13q14; IGH/CCND1;TP53)
- ☐ Follow-up CLL Panel (ATM; 12; 13q14; TP53)
- ☐ Diffuse Large B cell Lymphoma Panel (MYC; IGH/MYC; IGH/BCL2; BCL6; IGH)
- ☐ High Grade B cell Lymphoma Panel (BCL6; MYC; IGH/MYC; BCL2)
- ☐ MALT Lymphoma Panel (BCL6 for +3; MALT1; BIRC3/MALT1)
- ☐ Marginal Zone Lymphoma Panel (BCL6 for +3; 7/7q; TP53)
- ☐ Neuroblastoma Panel (MYCN/2cen; 1p36; ATM)
- ☐ Medulloblastoma Panel (MYCN; MYC; SEC63/6cen)
- ☐ Ependymoma Panel (1p36/1q25; CDKN2A; EGFR)
- ☐ IGH/CCND1
- ☐ IGH/BCL2
- ☐ IGH/MYC & MYC (BAP)

Additional FISH studies available.
Please see our website for complete FISH Test list or call the laboratory.

PATIENT LABEL HERE