UW Medicine
PATHOLOGY
CYTOGENETICS & GENOMICS

1959 NE Pacific St, **Room NW-125**, Seattle, WA 98195
Phone: 206-598-4488 | Fax: 206-598-2610
UWPathology.org/clinical/cytogenetics

NEOPLASIA TEST REQUEST FORM

For UW Pathology use	
MRN:	Accession #

1 Patient Information

First Name	MI	Last Name
Sex	DOB	SSN
Patient Address		
City	State	Zip
Patient Phone #	Outside Facility Patient ID	

2 Requesting Institution

Institution Name		
Institution Address		
City	State	Zip
Person Completing Form		
Phone	Fax	

3 Send Reports to

	Phone	Fax	NPI#
Requesting Physician (primary):	Phone	Fax	NPI#
Referring Physician/Surgeon:	Phone	Fax	NPI#
Referring Pathologist:	Phone	Fax	NPI#
Additional reports to:	Phone	Fax	NPI#

4 Billing Information

Payment Options: ☐ Patient Insurance* (If outpatient) ☐ Self-Pay (No insurance) ☐ Institution/Client Billing ☐ Split Billing / Medicare* (Pro to Patient, Tech to Client)

**Medicare Billing policy does not permit tech claims on laboratory testing for hospital inpatients/outpatients. These tech charges will be billed to the requesting institution.*

Primary Insurance			Secondary Insurance		
ID/Policy #	Group #		ID/Policy #	Group #	
Insurance Address	Phone		Insurance Address	Phone	
City/State/Zip			City/State/Zip		
Insured's Name	DOB	Relation to Pt:	Insured's Name	DOB	Relation to Pt:

Note: For sample collection requirements see https://dlmp.uw.edu/patient-care/cytogenetics

5 Specimen Type

Date obtained:

- ☐ Bone Marrow
- ☐ Bone Core Biopsy
- ☐ Leukemic Blood
- ☐ Fresh or Frozen Tumor (Site: ______________________________)
- ☐ Paraffin Blocks/Slides (Site: ______________________________)
- ☐ Other: ______________________________

6 Diagnosis or Indication for Testing

ICD-10 Code: ______________________________

Disease Phase:
- ☐ Pre-treatment or Relapse
- ☐ Post-treatment
- ☐ Post-transplant

7 Test(s) Requested

☐ **STAT** ☐ ROUTINE

- ☐ G-banded chromosome analysis and karyotyping
- ☐ Neoplasia Cytogenomic Microarray Analysis (CMA / CGH / CGAT / SNP Array)
- ☐ Single Neoplasia IFISH (specify locus or gene) ____________________ If: ☐ Normal ☐ Abnormal reflex to ____________________
- ☐ Neoplasia IFISH Panel (check one) *See **http://www.pathology.washington.edu/clinical/cytogenetics/** for loci included in panels.*

☐ AML	☐ Eosinophilia	☐ T-cell ALL	
☐ MDS / MPD (or CMML)	☐ CLL or SLL	☐ Adult B-cell ALL	☐ Glioblastoma
☐ B-cell Lymphoma	☐ Multiple Myeloma	☐ Childhood ALL	☐ Other: ____________

Ordering Provider Signature Required

Submitting a specimen with this requisition form indicates familiarity and agreement with applicable Reference Laboratory Services policies found at ***http://pathology.washington.edu/clinical/servicerequest***

Signature	**Date**