

MOLECULAR HEMATOLOGIC TESTING REQUISITION

Required Patient Information

Name: _____ Gender: M F
 MRN: _____ DOB: MM / DD / YYYY
 ICD10 Code(s): _____ / _____ / _____

ICD-10 Codes are required for billing. When ordering tests for which reimbursement will be sought, order only those tests that are medically necessary for the diagnosis and treatment of the patient.

Ordering Physician Information

Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Fax: _____
 NPI: _____

Billing & Collection Information

Patient Demographic/Billing/Insurance Form is required to be submitted with this form. Most genetic testing requires insurance prior authorization. Due to high insurance deductibles and member policy benefits, patients may elect to self-pay. Call for more information (855.916.4362)

Bill Client or Institution Client Name: _____ Client Code/Number: _____
 Bill Insurance Prior authorization or reference number: _____
 Patient Self-Pay Call for pricing and payment options Toll Free: 855.916.4362
 Patient status at time of collection: Inpatient Outpatient Collection date: _____ Collection time: _____

Providers are responsible to obtain informed consent, as required by Michigan law, for predictive or pre-symptomatic genetic tests. Informed Consent form is attached to this requisition, please submit with sample.

Sample/Source

Bone marrow in lavender (EDTA) top tube (minimum volume: 1 mL) | Specimen Stability: Ambient – 72 hours; Refrigerated – 1 week. **DO NOT FREEZE**
 Peripheral blood in lavender (EDTA) top tube (minimum volume: 3 mL) | Specimen Stability: Ambient – 72 hours; Refrigerated – 1 week. **DO NOT FREEZE**
 Extracted DNA/RNA: **ONLY ACCEPTED FROM CLIA CERTIFIED LABORATORIES**
 Note: For RNA tests, transport refrigerated blood (EDTA) within 72 hours of collection. If transport >72 hours, use PAXGene tube (call for supplies: 313.916.4DNA)
 Attach previous Hematology/Pathology report or provide HFH Case Number: _____

Hematologic Disorders

All tests include pathologist interpretation at a separate, additional charge.

<p>RNA Tests [RT-PCR]</p> <p><input type="checkbox"/> ALL - BCR/ABL1 t(9:22), p190 (81207)</p> <p><input type="checkbox"/> APL - PML/ RARA t(15:17) (81315)</p> <p><input type="checkbox"/> AML - CBFβ/ MYH11 inv(16) (81401)</p> <p><input type="checkbox"/> CML- BCR/ABL1 t(9:22), p210 (81206)</p>	<p>DNA Single Gene Tests</p> <p><input type="checkbox"/> B Cell Gene Rearrangement (81261)</p> <p><input type="checkbox"/> CALR Mutation (81219)</p> <p><input type="checkbox"/> FLT3 Mutation (81245, 81246)</p> <p><input type="checkbox"/> JAK-2 Mutation (81270)</p> <p><input type="checkbox"/> NPM1 Mutation (81310)</p> <p><input type="checkbox"/> T Cell Rearrangement- Beta (81340)</p> <p><input type="checkbox"/> T Cell Rearrangement- Gamma (81342)</p>
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Hematolymphoid NGS Panels

All tests include pathologist interpretation at a separate additional charge.

Hematolymphoid Neoplasm or Disorder Sequencing Panel (51 genes)
 ABL, ASXL1, ATRX, BCOR, BCORL1, BRAF, CALR, CBL, CBLB, CBLC, CEBPA, CSF3R, CUX1, DNMT3A, ETV6/TEL, EZH2, FBXW7, FLT3, GATA2, GNAS, HRAS, IDH1, IDH2, IKZF1, JAK2, KDM6A, KIT, KRAS, MLL, MPL, MYD88, NOTCH1, NPM1, NRAS, PDGFRA, PHF6, PTEN, PTPN11, RAD21, RUNX1, SETBP1, SF3B1, SMC1A, SMC3, SRSF2, STAG2, TET2, TP53, USAF1, WT1, ZRSR2 (81455)

DeNovo AML: CEBPA, DNMT3A, FLT3, KIT, IDH1, IDH2, NPM1, RUNX1, TET2, TP53, WT1 (81450)

Myeloproliferative Panel: JAK2 (12+14) CALR, MPL (81270, 81219, 81403)

Other Molecular Testing

Send Additional Report To

Name: _____
 Address: _____
 Phone #: _____ Fax #: _____



CENTER FOR
PRECISION DIAGNOSTICS

INFORMED CONSENT FOR GENETIC TESTING

PATIENT LAST NAME: (Please Print)	FIRST NAME:	MI:
DATE OF BIRTH: MM/DD/YYYY	PATIENT ID/MRN NUMBER:	
ORDERING PROVIDER INFORMATION (FULL LAST, FIRST): Name: Phone:	GENETIC TESTING REQUESTED FOR: _____ (name of condition)	
<p style="text-align: center;">SAMPLE TYPE</p> <input type="checkbox"/> Amniotic fluid <input type="checkbox"/> Blood <input type="checkbox"/> Cheek swab <input type="checkbox"/> Chorionic villus sample (CVS) <input type="checkbox"/> Skin <input type="checkbox"/> Tissue block <input type="checkbox"/> Other _____	The intended purpose is (check all that apply): <input type="checkbox"/> Carrier status <input type="checkbox"/> Diagnostic <input type="checkbox"/> Predictive <input type="checkbox"/> Prenatal <input type="checkbox"/> Pre-symptomatic <input type="checkbox"/> Screening <input type="checkbox"/> Other _____	

1. I have been informed about the nature and the purpose of this genetic testing.
2. I have received an explanation of the effectiveness and limitations of this genetic testing.
3. I have discussed the benefits and risks of this genetic test with my physician and/or other health care professional. I understand some genetic tests can involve possible medical, psychological or insurance issues for my family and I.
4. I understand the meaning of possible test results and have been informed how I will receive the result.
5. I have been informed that genetic testing can sometimes reveal secondary findings—results that are not related to the purpose of testing. I have discussed with my health care professional if and/or how such results will be shared with me. I understand that it is up to me to decide whether I want secondary results reported back to me and what secondary results I want reported.
6. If ordered by the ordering provider above, I authorize supplemental genetic testing to further aid in diagnosis, treatment and/or risk evaluation(s).
7. I have been informed who may have access to my biological sample, and that any leftover sample may be retained by the laboratory.
8. I have been informed who may have access to my genetic test result, which is part of my confidential medical record.
9. My questions have been answered to my satisfaction.
10. I understand that this consent form is intended to be used together with the patient information booklet that contains important information explaining the above eight items. I have read this consent form and understand that I can access the booklet electronically at: https://www.michigan.gov/documents/InformedConsent_69182_7.pdf
11. I received a copy of this form for my records.

I consent to have a sample taken for genetic testing on the above-named patient for the condition(s) listed above.

Signature of Patient or Authorized Designee

Date

Circle one: **Self** **Parent(s)** **Legal Guardian** **Durable Power of Attorney for Health Care**

Print Name of Physician or Authorized Delegee explaining the above information:

Signature of Authorized Person:

Date: