Henry Ford Health System
CENTER FOR PRECISION DIAGNOSTICS

Pathology and Laboratory Medicine
Clinic Building, K6, Core Lab, E-655
2799 W. Grand Blvd.
Detroit, MI 48202
855.916.4DNA (4362)

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.

RNA Tests [RT-PCR]

❑ ALL - BCR/ABL1 t(9:22), p190 (81207)
❑ APL - PML/RARA t(15:17) (81315)
❑ AML - CBFB/ MYH11 inv(16) (81401)
❑ CML- BCR/ABL1 t(9:22), p210 (81206)

DNA Single Gene Tests

❑ B Cell Gene Rearrangement (81261)
❑ CALR Mutation (81219)
❑ FLT3 Mutation (81245, 81246)
❑ IDH1 Mutation (81120)
❑ IDH2 Mutation (81121)
❑ JAK-2 Mutation (81279)
❑ MPL Mutation (81339)
❑ MYD88 Mutation (81305)
❑ NPM1 Mutation (81310)
❑ T Cell Rearrangement- Beta (81340)
❑ T Cell Rearrangement- Gamma (81342)
❑ TP53 Mutation (81351)

Hematolymphoid NGS Panels

All tests include pathologist interpretation at a separate additional charge.

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

❑ **Myeloproliferative Panel**: JAK2 (12+14) CALR, MPL (81219, 81279, 81339)

❑ **Hematolymphoid Neoplasm or Disorder Sequencing Panels** (Includes: *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*

❑ 1-4 genes (circle or highlight genes above) (CPT varies based on codes selected. Call for CPT coding)
❑ 5-50 genes (circle or highlight genes above) (81450)
❑ All genes listed above (81455)

Other Molecular Testing

Send Additional Report To

Name:
Address:
Phone #: Fax #:

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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:

SAMPLE TYPE

- ❑ Amniotic fluid
- ❑ Blood
- ❑ Cheek swab
- ❑ Chorionic villus sample (CVS)
- ❑ Skin
- ❑ Tissue block
- ❑ Other_____

GENETIC TESTING REQUESTED FOR:

_____
(name of condition)

The intended purpose is (check all that apply):

- ❑ Carrier status
- ❑ Diagnostic
- ❑ Predictive
- ❑ Prenatal
- ❑ Pre-symptomatic
- ❑ Screening
- ❑ 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: