UNIVERSITY OF MICHIGAN HOSPITALS & HEALTH CENTERS

DEPARTMENT OF PATHOLOGY
MOLECULAR DIAGNOSTICS LABORATORY
REQUISITION & PHYSICIAN ORDER FORM

☐ Routine
☐ STAT

ORDER DATE: _____ / _____ / _____
(mm/dd/yy)

☐ Bill research account # 7

ICD-9 Code/Diagnosis: ________________________________

Collected by: ________________________________

Collected Date: _____ / _____ / _____

Collection Time: ___________ am/pm

Attending Physician: (if different from above) ________________________________

Ordering Clinician to receive report: [ ] See label above

UMHS Dr. #: ________________________________

UMHS Dr. #: ________________________________

MOLECULAR DIAGNOSTIC LABORATORY

This request to order tests from the Molecular Diagnostics Laboratory certifies to the laboratory that (1) the ordering physician has obtained informed consent from the patient as required by applicable state or federal laws for each test ordered and (2) the ordering physician has authorization from the patient permitting the Molecular Diagnostics Laboratory to report results for each test ordered to the ordering physician.

For general information, call the Laboratory at 936-0565, M - F 8:00 - 4:30

TESTING WILL BE DELAYED OR NOT PERFORMED IF REQUISITION IS NOT COMPLETE!

SPECIMEN TYPE

☐ BLOOD ☐ BONE MARROW ☐ PARAFFIN BLOCK

(SOURCE) ________________________________

☐ TISSUE ☐ OTHER

(SEND FROZEN) SOURCE ________________________________

SURG PATH ID# ________________________________

PATIENT HISTORY/DIAGNOSIS:

HEMATOLOGY/ONCOLOGY

☐ KIT D816V Mutation
☐ NPM1 Mutation
☐ FLT3 Mutation
☐ CEBPA Mutation
☐ JAK2 (V617F) Mutation
☐ JAK2 Exon 12 Mutation
☐ JAK2 Exon 12 Mutation Analysis
☐ PML/RARA t(15;17) Translocation
☐ Quantitative BCR/ABL1 Analysis
☐ BCR/ABL1 Kinase Domain Mutation Analysis
☐ KMT2D Mutation Detection in Malignancy % tumor cells
☐ EGFR Mutation by Fragment Analysis % tumor cells
☐ KIT Mutation Detection for GIST  % tumor cells
☐ KIT Mutation Detection for Melanoma  % tumor cells

BRAF V600E Mutation
Microsatellite Instability
B Cell (IGH) Gene Rearrangement
T Cell (TCRgamma) Gene Rearrangement
IGH/BCL2 t(14;18) Translocation
SYT/SSX Translocation, Synovial Sarcoma
EWSR1/FLI1, EWSR1/ERG Translocation, Ewing Sarcoma
PAX/FOXO1 Translocation, Alveolar Rhabdomyosarcoma
EWSR1/WT1 Translocation, Desmoplastic Round Cell Tumor
EWSR1/ATF1 Translocation, Clear Cell Sarcoma
EWSR1 (22q12) Rearrangement by FISH
MYC (8q24) Rearrangement by FISH
HER2 FISH, Breast Cancer
UroVysion(TM) FISH for Bladder Cancer
Other

GENETICS

☐ Apolipoprotein E Genotype
☐ Factor V Leiden Mutation
☐ Prothrombin 20210 Mutation
☐ Hereditary Hemochromatosis
☐ Cystic Fibrosis Carrier Screen
(MUST INCLUDE PATIENT HISTORY FORM)
☐ Warfarin Sensitivity Analysis
☐ UGT1A1 Promoter Genotyping
☐ Other

BONE MARROW TRANSPLANT ENGRAFTMENT ASSESSMENT

☐ Pre-BMT RECIPIENT, Engraftment Analysis
☐ Pre-BMT DONOR, Engraftment Analysis

DONOR FOR:

Name: ________________________________
Reg#: ________________________________

☐ Post-BMT Engraftment Analysis
(Pre-BMT must have been previously performed)

Non-myeloablative transplant? ☐ Yes ☐ No
Fractionation? ☐ Yes ☐ No

Days post-transplant ________________________________

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LABORATORY

MOLECULAR DIAGNOSTICS
LABORATORY REQUISITION