NOTE: PLEASE REFER TO THE BACK OF THIS REQUISITION FOR SPECIMEN HANDLING INSTRUCTIONS

UNIVERSITY OF MICHIGAN HOSPITALS & HEALTH CENTERS

PATHOLOGY
Cytogenetics Laboratory Requisition

RESULTS REPORTING LOCATION CODE:

MRN:
NAME:
BIRTHDATE:
CSN:

☐ Routine
☐ STAT

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

ICD-10 Code/Diagnosis:		Ordering Clinician to receive report: ☐ See label above	
Collected by:			UMHS Dr. #:
Collected Date: _____/_____/_____	Collection Time: _____:_____am/pm	Attending Physician: (if different from above)	UMHS Dr. #:

CYTOGENETICS

SPECIMEN TYPE

☐ Peripheral Blood G
☐ Bone Marrow Aspirate G, syringe
☐ Bone Core*
☐ Lymph Node*
☐ Skin Biopsy*, Source: _____
☐ Tumor*, Source: _____
☐ Other _____
* = Media Tube

☐ Amniotic Fluid
☐ Chorionic Villi
☐ POC*
☐ Placenta*
☐ Fetal Tissue* Source: _____

Gest. Age: _____

DIAGNOSIS & CLINICAL HISTORY *(COMPLETE LEFT OR RIGHT COLUMN BELOW)*

CONSTITUTIONAL/GENETICS

DIAGNOSIS/INDICATION FOR TESTING:

CONSTITUTIONAL/GENETICS TESTS REQUESTED:

☐ Chromosome Analysis, Constitutional
☐ R/O Turner Syndrome

☐ Tissue Culture Only (Send out paperwork required)

FISH for Microdeletion Syndromes
☐ DiGeorge/VCF (22q11.2)
☐ Williams (7q11.23)
☐ Other _____

☐ FISH for CMA abnormality

MALIGNANCY

DIAGNOSIS:

COMPLETE THE FOLLOWING HISTORY:

☐ Initial specimen (pretreatment)
☐ Known to be complete remission
☐ Possible remission
☐ Possible relapse
☐ Known to have disease in relapse
☐ CML:
◇ chronic phase ◇ accelerating ◇ acute phase
☐ Pre-Transplant
☐ Post-Transplant Date of transplant: _____/_____/_____
◇ Auto ◇ Allo DONOR SEX: _____

TREATMENT HISTORY

Types of therapy received to date for current disease:
☐ None ☐ Radiotherapy ☐ Chemotherapy
☐ Gleevec ☐ Other (indicate drug): _____

If suspected second malignancy:
Primary malignancy/condition: _____
Treatment (e.g., RT, CT): _____
Date of treatment: _____/_____/_____

TESTS REQUESTED FOR MALIGNANCY:

☐ Chromosome Analysis, Malignancy

FISH Oncology Probes
☐ BCR/ABL [t(9;22)]
☐ PML/RARA [t(15;17)]
☐ RUNX1/RUNX1T1 [t(8:21)]
☐ CBFB/MYH11 [inv(16)]
☐ MLL [t(11q23)]
☐ PDGFRA/FIP1L1 (4q12)
☐ PDGFRB [t(5q32)]
☐ FGFR1 [t(8p12)]
☐ IGH/CCND1 [t(11;14)]
☐ CLL Panel
☐ Eosinophilia Panel
☐ Other: _____ (Lab approval required)

FFPE FISH:
☐ TFE3
☐ TFEB
☐ ERG

☐ Cancer Cytogenomic Microarray: G (Separate sample required)

21-10085 | VER: A/16 HIM: 1/16 | LABORATORY | University of Michigan Hospitals and Health Centers | Testing / Diagnostic / Screening Requisition

Replaces: 2019073