

**Division of Pathology / Laboratory Medicine
Outreach Services Test Requisition**

SHIP FLOW CYTOMETRY AND CYTOGENETICS TESTING TO:

6565 MD Anderson Blvd. Room Z5.4027
Houston, Texas 77030
Phone # 713 794 4639

SHIP HLA TESTING ONLY TO :

6565 MD Anderson Blvd., Room Z3.4028
Houston TX 77030
Phone: (713) 792-2658 / Fax: (832) 751-9867

SHIP MOLECULAR TESTING ONLY TO :

6565 MD Anderson Blvd., Room Z3.4023
Houston TX 77030
Phone: (713) 794-4780 / Fax: (713) 563-0031

***Required Fields
PHYSICIAN / FACILITY / CLIENT INFORMATION**

*REQUESTING PHYSICIAN		*UPIN / NPI NUMBER	
*PHONE	EXT	*FAX	HOSPITAL / OFFICE
ADDRESS	CITY	STATE	ZIP
PATIENT INFORMATION			
LAST NAME	FIRST NAME	DOB	SEX
ID NUMBER	PT. PHONE	SSN	
PT. ADDRESS	CITY	STATE	ZIP
INSURANCE PROVIDER	POLICY NUMBER	PHONE NUMBER	

SPECIMEN INFORMATION: Collection Date: ____/____/____ Time: ____ A / P

Specimen Type: Serum Plasma BM Urine PB Other _____

Diagnosis: _____

MICROBIOLOGY	MOLECULAR DIAGNOSTICS		
<input type="checkbox"/> CMV Antigenemia <input type="checkbox"/> Glactomanan (Aspergillus Ag)	<p>NOTE: Next Generation Sequencing (NGS) panels are NOT available for non-MD Anderson Patients</p> <p style="text-align: center;">Leukemia/Lymphoma Testing with Interp and Report</p> <p style="text-align: center;">Clonality Assays</p> <input type="checkbox"/> IGH/B-cell clonality (PCR) <input type="checkbox"/> TCR-beta/T-cell clonality (PCR) <input type="checkbox"/> TCR-gamma/T-cell clonality (PCR)		
FLOW CYTOMETRY	Translocation/Gene Fusions		
<input type="checkbox"/> Acute Leukemia Screen Panel <input type="checkbox"/> B-CLL/B-Cell Lymphoma Panel <input type="checkbox"/> Limited B-CLL Panel (CD5/CD19/CD38, kappa, lambda) <input type="checkbox"/> Hairy Cell Leukemia Panel <input type="checkbox"/> Myeloma Panel <input type="checkbox"/> Waldenstrom's Panel <input type="checkbox"/> T-Cell Lymphoma/Mycosis Fungoides (MF) Panel <input type="checkbox"/> Immunodeficiency Panel <input type="checkbox"/> CD4/CD8 ratio (PB only) <input type="checkbox"/> Transplant Panel <input type="checkbox"/> CD34 Assay <input type="checkbox"/> Other Markers Please specify: _____	<input type="checkbox"/> ABL1 mutation (full kinase domain sequencing) <input type="checkbox"/> ABL1 quantitative sequencing (codons 311-317/including T315I) <input type="checkbox"/> Acute myeloid/lymphoid leukemia translocation screen: BCR-ABL ; PML-RARA ; RUNX1-RUNX1T1 ; ETV6-RUNX1 ; E2A-PBX1 ; MLL-AF4 ; CBFB-MYH1 A,D,E ; DEK-CAN <input type="checkbox"/> t(9;22) BCR-ABL 1_Major (quant PCR) (e13a2(b2a2), e14a2(b3a2)) <input type="checkbox"/> t(9;22) BCR-ABL_Minor (quant PCR) (e1a2)	<input type="checkbox"/> BCR-ABL - t(9;22)_Alternative Transcript (qualitative PCR) (e13a2(b2a2), e14a2(b3a2), e1a2, e13 a3(b2a3), e14a3(b3a3), e1a3) <input type="checkbox"/> FIP1L1/PDGFR <input type="checkbox"/> Inv 16 (quant PCR) <input type="checkbox"/> t(8;21) (quant PCR) <input type="checkbox"/> t(11;14) MTC(quant PCR) <input type="checkbox"/> t(14;18) MBR (quant PCR) <input type="checkbox"/> t(15;17) (quant PCR)	
HISTOCOMPATIBILITY - HLA	Mutations (Point Mutations, Insertions, Deletions)		
PATIENT TYPING <input type="checkbox"/> HLA - Class I, Molecular [2L] <input type="checkbox"/> HLA - Class II, Molecular [2L] <input type="checkbox"/> Platelet Antibody <input type="checkbox"/> Other _____ DONOR TYPING <input type="checkbox"/> HLA Class I Molecular <input type="checkbox"/> HLA Class II Molecular DONOR INFORMATION Last Name: _____ First Name: _____ DOB: _____ Sex: _____ Race: _____ SSN or passport #: _____ Relationship to Patient: _____	<input type="checkbox"/> CALR mutation (exon 9) <input type="checkbox"/> CEBPA mutation <input type="checkbox"/> CSF3R mutation (exon 14, 17) <input type="checkbox"/> IDH1 mutation (codon 132) <input type="checkbox"/> IDH2 mutation (codon 140, 172) <input type="checkbox"/> JAK2 Exon 12 mutation <input type="checkbox"/> JAK2 mutation (codon 617)	<input type="checkbox"/> KIT mutation (exon 17) <input type="checkbox"/> KRAS mutation (codons 12, 13, 61) <input type="checkbox"/> NRAS mutation (codons 12, 13, 61) <input type="checkbox"/> MPL mutation (codon 515) <input type="checkbox"/> NPM1 mutation <input type="checkbox"/> MYD88 mutation (codon 265) <input type="checkbox"/> TP53 mutation (exons 2-11)	
	Transplant Studies with Interp and Report		
	<input type="checkbox"/> Post-Transplant Quantitative Chimerism Analysis:	<input type="checkbox"/> Myeloid cells (lineage-specific cell sorting) <input type="checkbox"/> T-cells (lineage-specific cell sorting)	
	Molecular for Solid Tumors (See Sample Requirements) with Interp and Report		
Comments:	<input type="checkbox"/> BRAF mutation (exons 11 or 15) <input type="checkbox"/> CTNNB1 <input type="checkbox"/> EGFR mutation	<input type="checkbox"/> KIT (exon 9, 11, 13, 17) <input type="checkbox"/> KRAS mutation (codon12, 13, 61) <input type="checkbox"/> Microsatellite Instability <input type="checkbox"/> MLH1 Promoter Methylation	<input type="checkbox"/> NRAS mutation <input type="checkbox"/> PDGFRA mutation <input type="checkbox"/> TP53 mutation (exons 2-11)
	CYTOGENETICS		
	<input type="checkbox"/> Conventional chromosome analysis <input type="checkbox"/> Fluorescence in situ hybridization (FISH) Specify Probe: _____		

DISCLOSURE

Disclosure of your social security number (SSN) is requested from you in order for The University of Texas M.D. Anderson Cancer Center to process your request for diagnostic services. No statute or other authority requires that you disclose your SSN for this purpose and we may not deny services if you choose not to disclose it. Failure to provide your SSN, however, may result in the creation of a duplicate patient number being issued, which may lead to multiple medical records. Further disclosure of your SSN is governed by the Texas Public Information Act and other applicable law. For questions related to the above information call at (800) 315-8424 or Fax (713) 745-1994.

**U.T. M.D. ANDERSON CANCER CENTER
DIVISION OF PATHOLOGY AND LABORATORY MEDICINE
ADMISSIONS AND NEW PATIENT REGISTRATION**

Blood _____
Tissue _____
Slides _____

MR # _____

REGISTRATION REQUEST

1. PATIENT INFORMATION

PATIENT NAME: _____

PATIENT'S ADDRESS: _____

PATIENT'S PHONE: _____

PATIENT'S DATE OF BIRTH: _____

PATIENT'S SOCIAL SECURITY #: _____

PATIENT'S SEX: _____ PATIENT'S MARITAL STATUS: _____

2. PRIMARY INSURANCE *will fax face sheet if secondary insurance is listed _____

INSURANCE COMPANY: _____

POLICY #: _____

ADDRESS: _____ TELEPHONE#: _____
EFFECTIVE DATE: _____

GROUP PLAN NAME: _____ GROUP PLAN #: _____

INSURED'S NAME (if different from patient): _____

RELATIONSHIP TO PATIENT: _____

INSURED'S SS#: _____

INSURED'S DOB: _____

3. GUARANTOR INFORMATION

SELF: _____

OTHER: (NAME) _____
(ADDRESS) _____

(PHONE) _____

4. MDACC SERVICE CODE: _____

MDACC PHYSICIAN CODE: _____

5. CONSULT REQUESTED BY: _____

PH# : _____

Disclosure of your social security number (SSN) is requested from you in order for The University of Texas M.D. Anderson Cancer Center to process your request for diagnostic services. No statute or other authority requires that you disclose your SSN for this purpose and we may not deny services if you choose not to disclose it. Failure to provide your SSN, however, may result in the creation of a duplicate patient number being issued, which may lead to multiple medical records. Further disclosure of your SSN is governed by the Texas Public Information Act and other applicable law.

For questions related to the above information call at (800) 315-8424 or Fax (713) 745-1994.

(Instructions for Flow Cytometry Testing)

**UTMDACC
Clinical Flow Cytometry**

**INSTRUCTIONS FOR COLLECTION AND SHIPMENT OF PATIENT
SPECIMEN FOR FLOW CYTOMETRY TESTING**

For **Bone Marrow Collection**: Draw 1-3cc of bone marrow in 10 ml EDTA Tube.

For **Peripheral Blood Collection**: Draw 10 ml of venous peripheral blood, using 10 ml EDTA Tube.

Label tubes with the following:

- **Patient's full name**
- **Date of Birth**
- **Patient's UTMDACC Number (if registered through Outreach Department 1-800-315-8424)**
- **Date and Time of Collection**
- **Initials of Phlebotomist**
CBC Differential
- **Diagnosis if known**

Package tubes and requisition form in a suitable mailer, on a cold pack, and ship both to UTMDACC, Laboratory (at address below). Customer/Sender must pay for shipping. Ship via Overnight Delivery Service.

Please note that the laboratory is **open 24hours Monday through Friday**. We will not accept delivery on weekends, or holidays or after 6PM on Friday. Therefore, coordinate specimen collection and shipping within these days and times.

Please contact us if you have any question regarding these instructions.

Telephone 713-794-4639

Email: FLOWLOG@mdanderson.org

Request for **Flow Cytometry Testing only** should be sent to:

6565 MD Anderson Blvd. Room Z5. 4027

Houston, Texas 77030

Phone # 713 794 4639

Please overnight delivery by UPS, DHL and FedEx

email tracking number to FLOWLOG@mdanderson.org

(Instructions for Cytogenetics Testing)

UTMDACC
Cytogenetics Laboratory
6565 MD Anderson Blvd., Room Z5.4000
Houston, Texas 77030

**INSTRUCTIONS FOR COLLECTION AND SHIPMENT OF PATIENT
SPECIMEN FOR CYTOGENETICS TESTING**

For **Bone Marrow Collection**: Draw 1-2cc of bone marrow in sodium heparin.

For **Peripheral Blood Collection**: Draw 10-20 ml of venous peripheral blood, using sterile sodium heparin tube (green top).

Label tubes with the following:

- **Patient's full name**
- **Date of Birth**
- **Patient's UTMDACC Number (if registered through Outreach Department 1-800-315-8424)**
- **Date and Time of Collection**
- **Initials of Phlebotomist**
CBC Differential
- **Diagnosis if known**

Package tubes and requisition form in a suitable mailer, on a cold pack, and ship both back to UTMDACC, Cytogenetics Laboratory (at address above), using AIRBORNE Shipping (Customer/Sender must pay for shipping). Ship via AIRBORNE'S Overnight Delivery Service.

Please note that the laboratory is **open Monday through Friday 7:00am-11pm only**. We will not accept delivery on weekends, or holidays. Therefore, coordinate specimen collection and shipping within these days and times. Please contact us if you have any question regarding these instructions.

Telephone: 713-792-6330
FAX: 713-745-3215

Request for **Cytogenetics Testing only** should be sent to:

6565 MD Anderson Blvd. Room Z5. 4027
Houston, Texas 77030
Phone # 713 794 4639

(Instructions for HLA Testing)

**UTMDACC
Histocompatibility Laboratory
6565 MD Anderson Blvd., Room Z3.4028,
Houston, Texas 77030**

**INSTRUCTIONS FOR COLLECTION AND SHIPMENT OF PATIENT
SPECIMEN FOR HLA TESTING**

For **Peripheral Blood Collection**: Draw venous peripheral blood, using sterile (2) 10 ml EDTA tubes for HLA Testing.

For **Patient's Only**: Draw above tubes and include an additional (1) 7 ml red top for Antibody Testing (if needed)

Label tubes with the following:

- **Patient's full name**
- **Date of Birth**
- **Patient's UTMDACC Number (if registered through Outreach Department 1-800-315- 8424)**
- **Date and Time of Collection**
- **Initials of Phlebotomist**

Package tubes and requisition form in a suitable mailer, at room temperature, and ship both back to UTMDACC, HLA Laboratory (at address above), using UPS Shipping (Customer/Sender must pay for shipping). Ship via UPS' Overnight Delivery Service. Please note that the laboratory is **open Monday through Friday 7:30 am - 7:30 pm only**. We will not accept delivery on weekends, or holidays. Therefore, coordinate specimen collection and shipping within these days and times.

Please contact us if you have any question regarding these instructions.

**Telephone: 713-792-2658
FAX: 832-751-9867**

Request for **HLA Testing Only** should be sent to:

**UT M. D. ANDERSON CANCER CENTER
Histocompatibility Laboratory
6565 MD Anderson Blvd., Room Z3.4028,
Houston, Texas 77030**

(Instructions for Molecular Testing)

**UTMDACC
Molecular Diagnostics Laboratory
6565 MD Anderson Blvd, Room Z3.4023
Houston, Texas 77030**

Collection and Transport of Specimens for Molecular Testing

To ensure optimum testing conditions for a specimen that is sent to the Molecular Diagnostics Laboratory (MDL) at MD Anderson Cancer Center (MDACC), the client should follow the below guidelines:

1. For ***Peripheral Blood**, collect 10-20 ml venous blood in EDTA (purple-top) vacutainer tubes. **All peripheral blood specimens must be accompanied with a CBC.**

For ***Bone Marrow**, collect 1-3 ml in EDTA. *It is important that a non-heparinized syringe is used for the initial bone marrow collection; then transferring the specimen to the sterile EDTA vacutainer tube without using a needle to dispense the sample.* **All bone marrow specimens must be accompanied with a BM Differential or pathology report.**

For ***Solid Tumor testing**, submit one H&E stained slide and 5-10 unstained slides depending on the amount of tumor tissue present. For a 0.4 uM thick tissue section of at least 0.5 cm² area, submit at least 5 slides. For smaller tissue sections, submit up to 10 slides. Microsatellite instability and some LOH testing require tissues from both normal (uninvolved) and tumor samples from the same patient. A paraffin block can also be sent. Send at room temperature. Consult with lab for additional questions. **All solid tumor specimens must be accompanied with a surgical pathology report.**

2. Identify the specimen(s) to be sent to MDL:
 - Patient's full name
 - Date of Birth (DOB)
 - Patient's MDACC# (if available)
 - Date and Time of Collection
 - Initials of Phlebotomist.
3. All EDTA tubes should be refrigerated immediately after collection and shipped with cold pack by overnight courier. **cDNA, genomic DNA and/or RNA directly for testing only if extraction or isolation was performed in a CLIA-certified laboratory. These should be shipped on dry ice for optimal preservation.*
4. Samples should be shipped by overnight carrier to arrive Tuesday- Friday by 4:00PM. Call **713-794-4780** for additional information.

Sender is responsible for shipping charges.

***Shipping Address: UTMDACC
Molecular Diagnostics Laboratory
6565 MD Anderson Blvd., Room Z3.4023
Houston, Texas 77030**