**WARDE MEDICAL LABORATORY**
**HEMATOLOGIC & NEOPLASTIC DISORDERS**
**CYTOGENETICS/FISH TEST REQUISITION**
734-214-0300 800-760-9969 Fax: 734-214-0399

**Patient Information**

Name: _____
Last First MI

Date of Birth: _____/_____/_____ Gender: _____

Patient ID: _____ Specimen ID: _____

*Referring Physician: _____ * Phone: _____

Pathologist_____ Phone: _____

*Indication for Test / Clinical Information:

_____

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**Test Requests/Specimen Type**

☐ Chromosome Analysis, Hematologic Disorder (CHRLSP) 10 mL Whole Blood Na Heparin or Bone Marrow (3.0 mL minimum)

**Fluorescence *in situ* hybridization (FISH):**

- ☐ Acute Myeloid leukemia (AMLFISH)
- ☐ ALK 2P23 (ALKFISH)
- ☐ BCR/ABL (Philchr) t(9;22) (BCRFISH)
- ☐ Chronic Lymphocytic Leukemia (CLLFISH)
- ☐ del(13)(q14.3) D13S319 (DELFISH)
- ☐ inv(16) & t(16:16) AML M4 (INV16FISH)
- ☐ Mantle Cell Lymphoma t(11;14) (MANTFISH)
- ☐ Multiple Myeloma 9 Panel (MMFISH)
- ☐ Myelodysplastic, Lowgrade (MDSLFISH)
- ☐ AML, t(8;21) (T821FISH)
- ☐ Acute Promyelocytic leukemia t(15;17) (PROFISH)
- ☐ BCL6 3q27 (BCLFISH)
- ☐ Burkitt Lymphoma t(8;14) (BURKFISH)
- ☐ Chronic Myelogenous Leukemia (CMLFISH)
- ☐ Follicular Lymphoma t(14;18) (FOLFISH)
- ☐ Malt Lymphoma (MALTFISH)
- ☐ MLL (11q23) (MLLFISH)
- ☐ Multiple Myeloma 5 Panel (MM5FISH)
- ☐ TEL-AML t(12;21) (TELFISH)
- ☐ PDGFRA del(4)(q12) (DELBYFISH)

☐ **Reflex to FISH testing above as necessary.**

Specimen Type: _____

Collection Date: _____ Time: _____

Additional Comments: _____

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* Required Fields