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:

_____

_____

Test Requests/Specimen Type

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

☐ Chromosome Analysis, Solid Tumor (CHRSTSP): Tissue in Tissue Transport Medium (TTM)

Fluorescence *in situ* hybridization (FISH):

☐ Acute Myeloid Leukemia Panel (AMLFISH)
☐ Plasma Cell Myeloma Complete Panel w/ IGH reflex (MMFISH)
☐ Plasma Cell Myeloma, 5 Probe Panel (MM5FISH)
☐ Chronic Lymphocytic Leukemia Panel (CLLFISH)
☐ MDS Panel (MDSLFISH)
☐ Acute Lymphoblastic Leukemia Panel
☐ Malt Lymphoma Study (Chromosome 3, MALT1) (MALTFISH)
☐ BCR/ABL1 [t(9;22)] (CMLFISH)
☐ PML/RARA [t(15;17)] (PROFISH)
☐ IGH/BCL2 [t(14;18)] (FOLFISH)
☐ CCND1 (BCL1)/IGH [t(11;14)] (MANTFISH)
☐ RUNX1T1/RUNX1 [t(8;21)] (T821FISH)
☐ CBFB/MYH11 [inv(16) & t(16:16)] (INV16FISH)
☐ MYC/IGH [t(8;14)] (BURKFISH)
☐ ALK (2p23) (ALKFISH)
☐ BCL6 (3q27) (BCLFISH)
☐ PDGFRA (DELBYFISH)
☐ PDGFRB
☐ FGFR1
☐ MLL (11q23) (MLLFISH)

☐ **Other FISH (Specify):**_____

☐ **Reflex to FISH testing above as necessary.**
☐ Chromosome Hold (CHRMHOLD)

Specimen Type: _____

Collection Date: _____ Time: _____

Additional Comments: _____

_____

_____

* Required Fields