

<p><b>PATIENT INFORMATION</b> (PLEASE PRINT IN BLACK INK)</p> <hr/> <p>Last Name _____ First _____ MI _____</p> <hr/> <p>Address _____ Birth Date _____ Sex <input type="checkbox"/> M <input type="checkbox"/> F</p> <hr/> <p>City _____ SS # _____</p> <hr/> <p>State _____ Zip _____ Home Phone _____</p> <hr/> <p>Hospital/Physician Office Patient ID # _____ Accession # _____</p> <hr/> <p>MEDICAL NECESSITY NOTICE: When ordering tests for which Medicare reimbursement will be sought, physicians (or other individuals authorized by law to order tests) should only order tests that are medically necessary for the diagnosis or treatment of a patient, rather than for screening purposes.</p> <p><b>INSURANCE BILLING INFORMATION</b> (PLEASE ATTACH CARD OR PRINT IN BLACK INK)</p> <p><b>BILL TO:</b> <input type="checkbox"/> Client/Institution <input type="checkbox"/> Medicare <input type="checkbox"/> Insurance (Complete insurance information below) <input type="checkbox"/> Patient</p> <p><b>PATIENT STATUS:</b> <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Non-Hospital Patient Hospital discharge date: ____/____/____</p> <p><b>WORKERS COMP:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No DOI: _____</p> <p><b>PRIMARY:</b> <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other Ins. _____ <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child</p> <hr/> <p>Subscriber Last Name _____ First _____ MI _____</p> <hr/> <p>Beneficiary / Member # _____ Group # _____</p> <hr/> <p>Claims Address _____ City _____ State _____ Zip _____</p> <p><b>SECONDARY:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, please attach) <b>ABN:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <hr/> <p><b>DIAGNOSIS CODE (REQUIRED)</b> ICD-10 Codes 1. _____ 2. _____ 3. _____</p> <hr/> <p><b>CLINICAL INFORMATION</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><b>CLIENT INFORMATION</b></p> <hr/> <p><b>ORDERING PHYSICIAN CONTACT</b></p> <p>Physician Name _____</p> <p>Physician NPI# _____</p> <p>Physician Phone _____</p> <p>Physician Email _____</p> <p><input type="checkbox"/> Call results to phone number: ( _____ ) _____</p> <p><input type="checkbox"/> Fax report to: ( _____ ) _____</p> <hr/> <p><b>SPECIMEN INFORMATION</b></p> <p>Please indicate number of tubes, vials, slides, tissue blocks provided.</p> <p>Collection Date: ____/____/____ Time: _____</p> <p>Body Site: _____ Specimen ID (#) s: _____</p> <p><input type="checkbox"/> Bone Marrow Biopsy*: Core _____ Clot _____ <i>*Must Provide CBC/WBC Differential and Pathology Report</i></p> <p><input type="checkbox"/> Bone Marrow Aspirate: Green top(s) _____ Purple top(s) _____ Other _____</p> <p><input type="checkbox"/> Peripheral Blood: Green top(s) _____ Purple top(s) _____ Other _____</p> <p><input type="checkbox"/> Smears: Air dried _____ Fixed _____ Stained (type of stain) _____</p> <p><input type="checkbox"/> Fluids: CSF _____ Pleural _____ FNA _____ Other _____</p> <p><input type="checkbox"/> Fresh Tissue: Tumor _____ or Lymph Node _____</p> <p><input type="checkbox"/> Paraffin blocks: Tissue block(s) _____ Cell block(s) _____</p> <p><input type="checkbox"/> Slides: Unstained _____ Stained _____</p> <hr/> <p><input type="checkbox"/> <b>Comprehensive Primary Bone Marrow Diagnostic Analysis</b> (Hematopathologist Directed) Includes clinical history review, morphology/microscopy, cytogenetic analysis &amp; summary report with correlation of all findings. May include flow cytometry, FISH and/or molecular testing as medically necessary.</p>				
<p><b>COMPREHENSIVE SERVICES</b> The Cleveland Clinic Hematopathologist is authorized to add other testing as needed to assist in evaluation. REQUIRED: Copy of most recent WBC/CBC, peripheral blood smears, two 4 ml green top tubes and one 4 ml lavender tops for bone marrow aspirate.</p>					
<p><b>INDIVIDUAL DIAGNOSTIC TESTS</b></p> <table border="0" style="width:100%;"> <tr> <td style="width:50%; vertical-align: top;"> <p><b>FLOW CYTOMETRY</b></p> <p><input type="checkbox"/> Leukemia/Lymphoma Panel <i>RLLLIP</i></p> <p><input type="checkbox"/> Lymphoma Panel for Tissue/Fluid <i>RLLYMP</i></p> <p><input type="checkbox"/> PNH, High Sensitivity, FLAER, Peripheral Blood Only <i>PNHPNL</i></p> <p><b>CHROMOSOME ANALYSIS</b></p> <p><input type="checkbox"/> Chromosome Analysis, Bone Marrow, Reflex to AML FISH <i>CHRAML</i></p> <p><input type="checkbox"/> Chromosome Analysis, Bone Marrow, Reflex to MDS FISH <i>CHRMDS</i></p> <p><input type="checkbox"/> Chromosome Analysis, Bone Marrow, Reflex to Microarray <i>BMCHF</i></p> <p><input type="checkbox"/> Cytogenetic Analysis, Bone Marrow <i>CHRBMH</i></p> <p><input type="checkbox"/> Cytogenetic Analysis, Leukemic Blood <i>CHRBLL</i></p> <p><input type="checkbox"/> Cytogenetic Analysis Lymph Node <i>CHRSOL</i></p> </td> <td 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## FISH PROBES AND SQ CODES

Test Name	Gene(s)	Location	SQ Acronym	Blood/ Marrow	Paraffin
FISH for BCL2	<i>BCL2</i>	18q21	BCL2FH	Y	Y
FISH for BCL6	<i>BCL6</i>	3q27	BCL6FH	Y	Y
FISH for BCR/ABL1	<i>BCR/ABL1</i>	t(9;22)	BCRF5H	Y	N
FISH for BIRC3/MALT1	<i>BIRC3/MALT1 (API2/MALT1)</i>	t(11;18)		N	Y
FISH for CBFβ/MYH11	<i>CBFB</i>	inv(16)	INV16F	Y	N
FISH for CCND1	<i>CCND1</i>	11q13	CCND1F	Y	Y
FISH for del (5q)	<i>EGR1</i>	5q31	5QFSH	Y	N
FISH for ETV6/RUNX1	<i>ETV6/RUNX1 (TEL/AML1)</i>	t(12;21)	1221FH	Y	N
FISH for FGFR1	<i>FGFR1</i>	8p12	FGFR1F	Y	N
FISH for IGH	<i>IGH</i>	14q32		N	Y
FISH for IGH/BCL2	<i>IGH/BCL2</i>	t(14;18)	FSHFCL	Y	Y
FISH for IGH/CCND1	<i>IGH/CCND1</i>	t(11;14)	FSHMCL	Y	Y
FISH for IGH/MYC	<i>IGH/MYC</i>	t(8;14)	814FSH	Y	Y
FISH for MALT1	<i>MALT1</i>	18q21		N	Y
FISH FOR MLL	<i>KMT2A (MLL)</i>	11q23	MLLFSH	Y	N
FISH for MYC(8q24)	<i>MYC</i>	8q24	MYCF5H	Y	Y
FISH for PDGFRA	<i>PDGFRA</i>	4q12	PDGFRA	Y	N
FISH for PDGFRB	<i>PDGFRB</i>	5q33	PDGFRB	Y	N
FISH for PML/RARA	<i>PML/RARA</i>	t(15;17)	APLFSH	Y	N
FISH for RARA	<i>RARA</i>	17q21	RARFSH	Y	N
FISH for 8;21 Translocation for AML	<i>RUNX1/RUNX1T1 (AML1/ETO)</i>	t(8;21)	AMLFSH	Y	N
FISH for Trisomy 4, 10	Trisomy 4/10	4 cen, 10 cen	FHT410	Y	N

Panel Names:	Probes		SQ Acronym	Blood/ Marrow?	Paraffin?
FISH for Acute Myeloid Leukemia	t(15;17), t(8;21), inv(16), MLL		FAMLPN	Y	N
FISH for B Lymphoblastic Leukemia (B-ALL)	t(9;22), MLL, t(12;21), 4/10 cen		FSHBLL	Y	N
FISH for Chronic Lymphocytic Leukemia	17p (TP53), 11q (ATM), 12 cen, 13q (D13S319,LAMP1)		CLLFSH	Y – peripheral blood only	N
FISH for Myelodysplastic Syndrome	5q (EGR1), 7q (D7S486), 8 cen, 20q (D20S108)		FSHMDS	Y	N
FISH for Myeloma (on plasma cells)	17p (TP53), 13q (RB1), 14q32 (IGH). If IGH pos, add t(11;14), t(4;14), t(14;16)		FSHPCM	Y	N
FISH for Myeloproliferative Neoplasms	t(9;22), 4q12 (PDGFRA), 5q33 (PDGFRB), 8p12 (FGFR1)		MPNFSH	Y	N