Stanford HEALTH CARE
STANFORD MEDICINE

Anatomic Pathology and Clinical Laboratories
Customer Service Toll Free (877) 717-3733

Cytogenetics (Heme/Oncology)

For Lab Use Only	Facility Name	Ordering Physician Name Last First
	Address	Physician NPI No.
	City, State, Zip	Physician Phone No. ( )
	Facility Phone Number ( )	Report Fax Number ( )

Patient Name (Last) (First)			Insurance Info: Attach a copy of front & back of Insurance card or face sheet ☐Private Ins/PPO ☐ Medicare ☐ Medi-Cal ☐ Patient ☐Client
Submitter ID Unique ID or MRN	DOB-Required	Sex M F	Responsible Party (Please Print)
Patient's Phone Number ( )	Collection Date & Time	Collection by- Required	Address
Copy to: First Name Last Name			City, State, Zip
Copy to complete address for mailing:			**ICD Code(s) - *REQUIRED INFORMATION*** Physician Signature: Date: Time:

Each individual test and CMS approved panel must have ICD code(s) to indicate the medical necessity of the test requested. Please provide all applicable ICD code(s) for the tests ordered. @ Tests for Medicare Patients Must be screened to determine if an Advanced Beneficiary Notice (ABN) is required. An ABN must be provided to the Medicare patient if there is a reason to believe Medicare will deny the test. Medicare may deny tests due to frequency. Medicare does not generally cover routine screening tests. *Continued on page 2.*

SAMPLE TYPE *(REQUIRED)*
- ☐Peripheral Blood
- ☐Bone Marrow Aspirate
- ☐Core Biopsy, Bone Marrow
- ☐Fresh Tissue; site _____ Type _____
- ☐ Fluid; type _____

Clinical History:

Check Suspected Diagnosis

Acute Leukemia	*Myelodysplastic Syndrome*
☐ AML type: _____	☐ Refractory Anemia ☐excess blasts? ☐ transformation?
☐ ALL type:_____	☐ CMML
Lymphoproliferative Ds.	*Myeloproliferative Disorder*
☐ Lymphoma Type:_____	☐ CML
☐ CLL	☐ Polycythemia Vera
☐ Myeloma	☐ Thrombocythemia
☐ Other:_____	☐ Myelofibrosis

BMT/Therapy Status

Recent Chemotherapy? ☐No ☐ Yes; Date_____ Transplant Type? ☐ Auto ☐ Allo

Status Post Transplant? ☐ No ☐ Yes; Date_____ Donor Sex: ☐ Male ☐ Female

CHROMOSOME ANALYSIS

√	Test Name	Test code
☐	Bone Marrow, Analysis	CG BONE MRW
☐	Peripheral Blood, Analysis WBC_____, % BLASTS_____	CG BLD NEO
☐	Tumor, Analysis (Diagnosis_____)	CG TUM
☐	Peripheral Blood, Analysis *for constitutional karyoytpe analysis only*	CG BLOOD

FISH ANALYSIS

√	Test Name		Test code
☐	BCR/ABL1 t(9;22)	(CML, ALL)	CGFi BCR
☐	PML/RARA t(15;17)	(APL)	CGFi APL
☐	RUNX1T1/RUNX1 t(8;21)	(AML)	CGFi t(8;21)
☐	CBFB inv(16)	(AML-eo)	CGFi inv(16)
☐	MLL (KMT2A) 11q23	(AML, ALL)	CGFi MLL
☐	ETV6/RUNX1 t(12;21)	(ALL)	CGFi TEL
☐	del(5q) 5q deletion	(MDS/AML)	CGFi 5Q
☐	del(7q) 7q deletion	(MDS/AML)	CGFi 7Q
☐	del(20q) 20q deletion	(MDS/AML)	CGFi 20Q
☐	MDS panel (del(5q), -7/del(7q), +8, del(20q))		CGFi MDSpan
☐	del(13q) 13q deletion (myeloma, CLL, MDS)		CGFi 13Q
☐	CLL panel (+12, ATM, del(13q), P53)		CGFi CLL
☐	Enumeration (+8, hyperdiploidy, X/Y, etc.) specify chromosome(s)_____		CGFi ENUM

√	Test Name		Test code
☐	Myeloma panel (t(11;14), del(13q), P53, reflex)		CGFi Mmpan
☐	CHIC2 FIPIL1/PDGFRA (HES, CEL)		CGFi CHIC2
☐	FGFR1 t(8q11.2)	(eosinophilia)	CGFi FGFR1
☐	PDGFRB t(5q33)	(eosinophilia)	CGFi INTPH
☐	IGH t(14q32)	(lymphoprolif. disorders)	CGGi IGH
☐	BCL2 t(14;18)	(follicular lymphoma)	CGFi FCL
☐	BCL6 t(3q27)	(lymphoma)	CGFi FCL
☐	MYC t(8;14), var.	(Burkitt, DLBCL)	CGFi cMYC
☐	CCND1/IGH t(11;14)	(mantle cell lymphoma)	CGFi MCL
☐	EWSR1 (Ewings, PNET, DSRCT, other)		CGFi EWS
☐	SS18 (SYT) (synovial sarcoma)		CGFi SYT
☐	FOXO1 (FKHR) (alveolar rhabdomyosarcoma)		CGFi INTPH
☐	OTHER TESTS (Be Specific)_____		

(12/2014)

STANFORD SPECIMEN REQUIREMENTS

For Specimen collection questions you may call the testing laboratory at the phone number listed next to the department name or contact our Customer Service department at 1-877-717-3733.
Specimen requirements can also be found on www.stanfordlab.com.

First sample collected should always be a green top (sodium heparin) tube when Blood, Chromosome Analysis is requested.

CHROMOSOME ANALYSIS & FLUORESCENCE IN SITU HYBRIDIZATION (FISH)	**Lab Phone Number (650) 725-6396**
Chromosome Analysis and FISH testing can be performed from a single patient sample if volume is adequate	
Bone Marrow	· Minimum 1-2 mL · Green-top (sodium heparin) tube · Maintain specimen at room temperature
Whole Blood	· Minimum 4 mL · Green-top (sodium heparin) tube · Maintain specimen at room temperature
Tissue	· 0.5-1 cm^3 tissue · Sterile tube containing RPMI cell culture media, Sterile saline acceptable if media unavailable

Ship to:
If shipping Friday check for Saturday delivery
Phone: 1 (877) 717-3733

Stanford Anatomic Pathology and Clinical Laboratory
Attn: Specimen Processing
3375 Hillview Ave
Palo Alto, CA 94304

Shipper's Responsibility: The shipper is required to comply with the rules and guidelines for transport of medical specimens as set forth by the United States government, the government of the country of origin and international regulatory agencies. Failure to follow instructions for packaging and shipping specimens can result in the delay, loss or destruction of your specimens. Stanford University Medical Center Clinical Laboratories will not be held responsible for any liability attributable to the shipper's improper actions or failure to comply with regulations.

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Section 1862(a)(1)(A) of the Social Security Act states, "no payment may be made under Part A or Part B for any expense incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of any illness or to improve the functioning of a malformed body member." Tests submitted for Medicare reimbursement must meet program requirements or the claim may be denied. @ This test is subject to Medicare NCD or LCD, coverage is limited to certain diagnoses that support medical necessity.

Patient's First Name:_____

Patient's Last Name: _____

Patient's MRN: _____

Or Affix Label Here

Stanford HEALTH CARE

STANFORD MEDICINE

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. Options: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D.** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date: