Stanford HEALTH CARE STANFORD MEDICINE

Anatomic Pathology and Clinical Laboratories
Customer Service Toll Free 1(877) 717-3733

Hematopathology

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:

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. 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.

COMPREHENSIVE TESTING (COMPHE) Collect one 4 mL green top sodium heparin & two 4 mL lavender top tubes (See 2nd page for tissue information)

☐**COMPREHENSIVE TESTING WITH INTERPRETATION** (Testing performed as indicated by pathologist after review of morphology and histology) Include morphology, histology, special stains, immunohistochemistry, flow cytometry, cytogenetics, FISH and molecular pathology as needed.

SAMPLE TYPE (*REQUIRED*)

☐Peripheral Blood ☐ Fluid; type ___________
☐Bone Marrow Aspirate ☐ FNA; site ___________
☐Core Biopsy, Bone Marrow
☐Slides; site ___________ Slide No. ___________
☐Fresh Tissue; site ___________ Type ___________
☐Paraffin Block; site _________ Block No. ___________

Clinical History:

MORPHOLOGY/HISTOLOGY

☐Peripheral blood smear interpretation
☐Bone marrow aspirate interpretation
☐Bone marrow biopsy
☐Biopsy, NOS: Site:_________________
☐Cytology review, NOS Site:

SPECIAL STAINS

☐Iron stain
☐Reticulin stain
☐Trichrome stain

HEMATOLOGY

☐CBC w/ differential w/ slide review @(**CBCS**)
☐Reticulocyte count (**RETIC**)

FLOW CYTOMETRY (FCPATH)

☐Immunophenotyping (Leukemia/Lymphoma/Myeloma/MDS) **(ANTIBODY PANEL SELECTED BY PATHOLOGIST)**
☐Paroxysmal Nocturnal Hemoglobinuria (PNH) Screen ☐Other / Comment: ______________________________

CHROMOSOME STUDIES (CYTGEN)

☐Bone Marrow Cytogenetics Analysis @
☐Blood, Leukemic Cytogenetic Analysis @ WBC___________ % Blasts _______________
(Blood must have circulating blasts when bone marrow is unobtainable)

FLUORESCENCE *IN SITU* HYBRIDIZATION (CYTGEN)

Myeloid Neoplasms

☐ BCR/ABL1 t(9;22) (CML, ALL)**
☐ CBFB (inv16) (AML)
☐ CHIC2 (FIP1L1/PDGFRA) (HES, CEL, SMCD)
☐ RUNX1T1/RUNX1 t(8;21) (AML)
☐ MDS Panel (-5/5q-, -7/7q-, +8, 20q-)
☐ MLL Rearrangement (11q23) (AML, ALL)**
☐ PML/RARα t(15;17) (APL)
☐ -5/5q- del(5q)/monosomy 5 (MDS, AML)
☐ -7/7q- del(7q)/monosomy 7 (MDS, AML)
☐ Enumeration (+8 , hyperdiploidy, X/Y, other)

Lymphoid Neoplasms

☐ CCND1/IGH t(11;14) mantle cell lymphoma
☐ CLL Panel: Includes (+12, ATM, del(13q), P53)
☐ DLBCL Panel: Includes (BCL2, BCL6, MYC)
☐ IGH/BCL2 t(14;18) (follicular lymphoma)
☐ MYC t(8;14) Burkitt lymph/B-ALL
☐ Myeloma Panel: t(11;14), del(13q), P53 reflex to t(4 ;14), t(14 ;16)
☐ P53 del(17p) (CLL, myeloma, other)
☐ ETV6/RUNX1 t(12;21) (pre-B ALL)
☐ Other_______________________________

MOLECULAR PATHOLOGY

☐ Cancer Somatic Mutation Panel by Next Gen Seq. *Include Pathology report* ▼

Myeloid Neoplasms

☐ AML -NPM1 & FLT3 ■
☐ BCR-ABL ◆**
☐ BCR-ABL Kinase Domain Mutation◆
☐ Calreticulin Mutation Detection
☐ CEBPA by sequencing ■
☐ KIT Mutation Analysis (exon 8 & 17) ◆■
☐ KIT D816V Mutation

Myeloid Neoplasms

☐ JAK2 V617F (1849G>T), Quantitative
☐ MYD88 Mutation(L265P, 794T>C)
☐ PML-RARα t(15;17),Quant ◆
☐ SF3B1 by sequencing **

Lymphoid Neoplasms

☐ B-Cell Clonality
☐ T-Cell Clonality
☐ VH Mutation Analysis

** Also used in Lymphoid Neoplasms ◆RNA studies: Ship on cool packs ■ Provide the % blasts in sample submitted

▼A complete list of detected mutations for the Cancer Somatic Mutation Panel can be found at www.stanfordlab.com.

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 Chromosome Analysis is requested.

FLOW CYTOMETRY	Lab Phone Number: (650) 724-2250
Whole Blood	· Minimum 4 mL · Lavender-top (EDTA) tube · Maintain specimen at room temperature · Peripheral blood smear requested but not required
Bone Marrow	· Minimum 2 mL · Lavender-top (EDTA) tube or green-top (sodium heparin) tube · Maintain specimen at room temperature · Aspirate smear requested but not required
Core Biopsy or Fresh Tissue	· 0.5-1 cm^3 tissue · Sterile tube containing RPMI cell media · Maintain specimen at room temperature
Fluid (pleural, effusion, ascites etc.)	· Minimum 7 mL · Lavender-top (EDTA) tube or sterile tube · Maintain specimen at room temperature

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	
Whole Blood	· Minimum 4 mL · Green-top (sodium heparin) tube · Maintain specimen at room temperature · **Blood must have circulating blasts when bone marrow is unobtainable**
Bone Marrow	· Minimum 1-2 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 · Paraffin embedded tissue (FISH)

MOLECULAR PATHOLOGY	Lab Phone Number (650) 723-6574
Specimens with suspected acute leukemia or myeloid neoplasms must be shipped on cool packs.	
Whole Blood **Provide % blast in sample submitted**	· Minimum 4 mL · Lavender-top (EDTA) tubes · RNA Studies –ship on wet ice, DNA Studies ship at room temperature
Bone Marrow **Provide % blast in sample submitted**	· Minimum 1-2 mL · Lavender-top (EDTA) tubes · Maintain specimen at room temperature
Tissue **Enclose a copy of the patient's Pathology Report**	· FFPE tissue · Maintain specimen at room temperature ✹ **Provide % tumor in sample submitted or H & E stained slide of block submitted**
Fluid	· Volume varies, contact laboratory · Sterile tube · Maintain specimen at room temperature

Ship to:
If shipping Friday check for Saturday delivery
Phone: 1(877) 717-3733
Fax delivery notification to: (650) 724-4758

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.

* ICD Code(s) based on present CMS guidelines.

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:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.