

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 <input type="checkbox"/> Private Ins/PPO <input type="checkbox"/> Medicare <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Patient <input type="checkbox"/> Client		
Client Acct # 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:	<b>ICD Code(s) - REQUIRED INFORMATION</b>		
	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 codes 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.

**SAMPLE TYPE**

<input type="checkbox"/> Peripheral Blood	<input type="checkbox"/> Fresh Tissue; site _____ Type _____	<input type="checkbox"/> Fluid; type _____
<input type="checkbox"/> Bone Marrow Aspirate	<input type="checkbox"/> Paraffin Block; site _____ Block No. _____	<input type="checkbox"/> Slides; site _____
■ % blast in sample submitted _____	✱ % tumor in sample submitted _____	<input type="checkbox"/> Slide No. _____

**CLINICAL HISTORY**

Signs/Symptoms: \_\_\_\_\_ Prior Diagnosis \_\_\_\_\_  
Suspected Diagnosis: \_\_\_\_\_

**MOLECULAR PATHOLOGY**

<input type="checkbox"/> Alpha Thalassemia/Hb Constant Spring (ATHAL, FATHAL, TATHAL)	<input type="checkbox"/> Familiar Gastric Cancer (CDH1) (CDH1, CDHPET)
<input type="checkbox"/> AML - NMP1 Mutation and Referred FLT3 Analysis ■ (NPM1/BMNP1&12571R)	<input type="checkbox"/> Known Mutation, Exon: _____ (complete CDH1 requisition)
<input type="checkbox"/> B-Cell Clonality ✱ (BCLON, FBCLO, TBCLO, BMBCLO)	<input type="checkbox"/> JAK2 V617F (1849G>T), Quantitative (JAK2, NJAK2)
<input type="checkbox"/> BCR-ABL, Qualitative t(9;22) ◆ (BCRABL, BMBCR, TBCR)	<input type="checkbox"/> KIT D816V Include Pathology report ✱ (D816V/ ND816V)
<input type="checkbox"/> BCR-ABL, Quantitative ◆ (BCRQT, BMBCRQ, FBCRQT)	<input type="checkbox"/> KRAS Include Pathology report ✱ (KRAS)
<input type="checkbox"/> BCR-ABL Kinase Domain Mutation Analysis ◆ (BCRKDM)	<input type="checkbox"/> MGMT by Methylation Specific PCR ✱ (MGMT)
<input type="checkbox"/> Beta Thalassemia Sequencing (BTHSQ, FBTHSQ)	<input type="checkbox"/> MTHF Reductase 677C>T, 1298>C (MTHFR)
<input type="checkbox"/> BRAF by PCR Include Pathology report ✱ (BRAF)	<input type="checkbox"/> PML-RARα t(15;17), Quant ◆ (T1517, BM1517, FT1517, T1517)
<input type="checkbox"/> Cancer Somatic Mutation Profile Include Pathology report ✱ ▼ (CSMP)	<input type="checkbox"/> Prothrombin-20210A Mutation (P20210)
<input type="checkbox"/> CEBPA by sequencing ■ (CEBPA, BMCEBP)	<input type="checkbox"/> Detection of t(11;14) BCL1 / JH (CCND1, CyclinD1) (T1114, BM1114, FT1114, TT1114)
<input type="checkbox"/> c-KIT Mutation Analysis (CKITMU)	<input type="checkbox"/> Detection of t(14;18) BCL2/JH (follicular and other Lymphomas) (T1418, BM1418, FT1418, TT1418)
<input type="checkbox"/> EGFR Gene Mutation Panel Include Pathology report ✱ (EGFR)	<input type="checkbox"/> T-Cell Clonality ✱ (TCLON, BMTCLO, FTCLO, TTCLO)
<input type="checkbox"/> Factor V Leiden (LEID)	<input type="checkbox"/> VH Mutation Analysis (VHHA, NVHHA)
<input type="checkbox"/> Familial Gastric Cancer (CDH1) by sequencing Whole Blood or FFPE Normal Tissue (CDH1, CDHPET) (complete CDH1 requisition)	

Microsatellite Instability by PCR NOTE: submit a normal block or peripheral blood with tumor sample Include Pathology report ✱ (TMSI)

Extract RNA for future testing (RNAISO)  Extract DNA for future testing (DNAISO)

Other:

◆ RNA Studies -ship on wet ice ■ Provide the % blasts in sample submitted ✱ Provide the % tumor in sample submitted  
CDH1 requisition can be found at [http://www.stanfordlab.com/pages/test\\_requisitions.htm](http://www.stanfordlab.com/pages/test_requisitions.htm)  
▼ A complete list of detected mutations for the Cancer Somatic Mutation Profile can be found at [www.stanfordlab.com](http://www.stanfordlab.com)

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		Facility Phone Number ( ) ( )		Report Fax Number ( ) ( )		
Patient Name (Last) (First)			Insurance Info: Attach a copy of front & back of Insurance card or face sheet <input type="checkbox"/> Private Ins/PPO <input type="checkbox"/> Medicare <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Patient <input type="checkbox"/> Client			
Client Acct # Unique ID or MRN		DOB-Required	Sex M F	Responsible Party ( Please Print)		
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Copy to complete address for mailing:						
<p>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 codes 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.</p>						
<b>SAMPLE TYPE</b>						
<input type="checkbox"/> Peripheral Blood		<input type="checkbox"/> Fresh Tissue; site _____		Type _____		
<input type="checkbox"/> Fluid; type _____		<input type="checkbox"/> Paraffin Block; site _____		Block No. _____		
<b>CLINICAL HISTORY</b>						
Signs/Symptoms: _____			Prior Diagnosis: _____			
Suspected Diagnosis: _____						
<b>MOLECULAR PATHOLOGY</b>						
<input type="checkbox"/> Achondroplasia / Hypochondroplasia (CHON)		<input type="checkbox"/> Familial Gastric Cancer (CDH1) by sequencing Whole Blood or FFPE Normal Tissue (complete CDH1 requisition)		(CDH1, CDHPET)		
<input type="checkbox"/> Alpha Thalassemia/Hb Constant Spring (ATHAL, FATHAL, TATHAL)		<input type="checkbox"/> Familial Gastric Cancer (CDH1) (complete CDH1 requisition) Known Mutation, Exon: _____		(CDH1, CDHPET)		
<input type="checkbox"/> Beta Thalassemia Sequencing (BTBSQ, FBTHSQ)		<input type="checkbox"/> FGFR1 Craniosynostosis		FGFR1		
<input type="checkbox"/> Biotinidase Sequencing Assay (BIOA)		<input type="checkbox"/> FGFR2 Craniosynostosis		FGFR2		
<input type="checkbox"/> CF 32, Cystic Fibrosis, DNA (CF32, NCF32)		<input type="checkbox"/> FGFR3 Muenke		FGFR3		
<input type="checkbox"/> CFTR Deletion/Duplication Analysis by MLPA (CFMLPA)		<input type="checkbox"/> Fragile X , DNA		FRAGX		
<input type="checkbox"/> CF TR Diagnostic Sequencing Assay (Full gene) (CFDS)		<input type="checkbox"/> MTHF Reductase 677C>T, 1298>C		MTHFR		
<input type="checkbox"/> CF TR Sequencing Assay Exon specific (CFDS)		<input type="checkbox"/> Pendred Syndrome by sequencing		PDS		
List mutation(s): _____		<input type="checkbox"/> Prader-Willi Syndrome (PWS), RNA ◆		PWS		
<input type="checkbox"/> Connexin 26, Sequencing (CX26S, FCX26S)		<input type="checkbox"/> Prothrombin-20210A Mutation		P20210		
<input type="checkbox"/> Connexin 30 (CX30)						
<input type="checkbox"/> Duchenne and Becker Muscular Dystrophy, DNA (DBMD)						
<input type="checkbox"/> Factor V Leiden (LEID)						
<input type="checkbox"/> Maternal Cell Contamination		<input type="checkbox"/> Amniotic Fluid, (FMCC & MCC)				
Maternal whole blood (4mL EDTA) required with prenatal sample submission when molecular testing is requested.				<input type="checkbox"/> CVS, (TMCC & MCC)		
<input type="checkbox"/> Other						
<b>◆ RNA Studies –ship on wet ice</b> <span style="color:red;">CDH1 requisition can be found at <a href="http://www.stanfordlab.com/pages/test_requisitions.htm">http://www.stanfordlab.com/pages/test_requisitions.htm</a></span>						

## 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](http://www.stanfordlab.com).

MOLECULAR PATHOLOGY	Lab Phone Number (650) 723-6574
Whole Blood	<ul style="list-style-type: none"> <li>• Minimum 4 mL</li> <li>• Lavender-top (EDTA) tubes</li> <li><b>RNA Studies –ship on wet ice, DNA Studies ship at room temperature</b></li> <li>■ <b>Provide % blast in sample submitted</b></li> </ul>
Bone Marrow	<ul style="list-style-type: none"> <li>• 1-2 mL Bone Marrow</li> <li>• Lavender-top (EDTA) tubes</li> <li>• Maintain specimen at room temperature</li> <li>■ <b>Provide % blast in sample submitted</b></li> </ul>
Tissue	<ul style="list-style-type: none"> <li>• 0.5-1 cm<sup>3</sup> tissue</li> <li>• Frozen Tissue –maintain frozen and send on dry ice</li> <li>• Fresh Tissue –Send sterile tube containing RPMI cell culture media</li> <li>• Paraffin embedded tissue: room temperature</li> <li><b>Enclose a copy of the patient's Pathology Report</b></li> <li>✱ <b>Provide % tumor in sample submitted</b></li> <li><b>CHD1 by Sequencing requires FFPE Normal Tissue</b></li> </ul>
Fluid	<ul style="list-style-type: none"> <li>• Volume varies, contact laboratory</li> <li>• Sterile tube</li> <li>• Maintain specimen at room temperature</li> </ul>

**Ship to:**  
**If shipping Friday check for Saturday**  
**delivery**

Phone: 1 (877) 717-3733

Fax delivery notification to: (650) 724-4758

**Stanford's 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.