

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

Patient Name - Required (Last) (First)		Billing Info <input type="checkbox"/> Copy of Front & Back of Ins. Card Attached	
Location Unique Identifier or MRN		<input type="checkbox"/> Private Ins./PPO <input type="checkbox"/> Medicare <input type="checkbox"/> Inpatient <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Client <input type="checkbox"/> Outpatient	
Patient's Phone Number ()	Collection Date & Time - Required	DOB - Required	Sex M F
Responsible Party (Please Print)		Street Address	
Copy to: First Name Last Name		City, State, Zip	
Address:		Ph. ()	
		Fax ()	
		ICD9 Code(s) - REQUIRED INFORMATION	
		Physician signature: _____ Date: _____	

Each individual test and CMS approved panel must have ICD-9 code(s) to indicate the medical necessity of the test requested. Please provide all applicable ICD-9 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"/> Fluid - Type: _____	<input type="checkbox"/> FNA - Site: _____
<input type="checkbox"/> Bone Marrow Aspirate	<input type="checkbox"/> Fresh Tissue - Site: _____ Type: _____	<input type="checkbox"/> Slides - Site: _____
<input type="checkbox"/> Core Biopsy, Bone Marrow	<input type="checkbox"/> Paraffin Block - Site: _____ Block No. _____	<input type="checkbox"/> Slide No. _____

CLINICAL HISTORY

Signs/Symptoms: _____
 Suspected Diagnosis: _____
 Prior Diagnosis: _____

Therapy in Past Month? Chemo/Rad G-CSF
 Hematopoietic Cell Transplant? Date: _____
 Auto Allo Donor Sex: Male Female

FLOW CYTOMETRY (Sunquest Code: FCPATH)

Immunophenotyping - **LAB067** (Leukemia/Lymphoma/Myeloma/MDS) (Antibody panel selected by pathologist)
 Paroxysmal Nocturnal Hemoglobinuria (PHN) Screen - **LAB070** Other / Comment: _____

CHROMOSOME STUDIES (Sunquest Code: CYTGEN)

Bone Marrow Cytogenetic Analysis (**CG BONE MRW**) Blood, Leukemic Cytogenetic Analysis (**CG BLD NEO**) WBC _____% Blasts _____
 Solid Tumor Cytogenetic Analysis (**CG TUM**) (Blood must have circulating blast when bone marrow is unobtainable)

FLUORESCENCE IN SITU HYBRIDIZATION (FISH) (Sunquest Code: CYTGEN)

<input type="checkbox"/> PML/RARA: t(15;17) (APL) (CGFi APL)	<input type="checkbox"/> CLL Panel: (+12, ATM, del(13q), P53) (CGFi CLL)
<input type="checkbox"/> BCR/ABL1: t(9;22) (CML, ALL) (CGFi BCR)	<input type="checkbox"/> Myeloma Panel: [t(11;14), del(13q), P53 reflex to t(4;14), t(14;16)] (CGFi MM)
<input type="checkbox"/> ETO/AML1: t(8;21) (AML) (CGFi t(8;21))	<input type="checkbox"/> del(13q) 13q deletion (CLL, myeloma, other) (CGFi 13Q)
<input type="checkbox"/> CBFB inv(16) (AML) (CGFi inv(16) (CGFi MLL))	<input type="checkbox"/> P53: del(17p) (CLL, myeloma, other) (CGFi P53)
<input type="checkbox"/> MLL: (11q23) (AML, ALL) (CGFi MLL)	<input type="checkbox"/> CCND1/IGH: t(11;14) (mantle cell lymphoma) (CGFi MCL)
<input type="checkbox"/> TEL/AML1: t(12;21) (pre-B ALL) (CGFi TEL)	<input type="checkbox"/> CMYC: t(8;14) (Burkitt lymph/B-ALL) (CGFi MYC)
<input type="checkbox"/> -5/5q-: del(5q)/monosomy 5 (MDS, AML) (CGFi 5Q)	<input type="checkbox"/> IGH/BCL2: t(14;18) (follicular lymphoma) (CGFi FCL)
<input type="checkbox"/> -7/7q-: del(7q)/monosomy 7 (MDS, AML) (CGFi 7Q)	<input type="checkbox"/> EWS: (Ewings / PNET, Other) (CGFi EWS)
<input type="checkbox"/> CHIC2 (FIP1L1/PDGFR): (HES, CEL, SMCD) (CGFi CHIC2)	<input type="checkbox"/> SYT: (Synovial sarcoma) (CGFi SYT)
<input type="checkbox"/> Enumeration: (+8, hyperdiploidy, X/Y, other) (CGFi ENUM) Specify: _____	<input type="checkbox"/> Other (specify): _____

MOLECULAR PATHOLOGY

<input type="checkbox"/> BCR/ABL by PCR Qualitative (BCRABL/BMBCR/TBCR)	<input type="checkbox"/> Detection of t(11;14), DNA (T1114/BM1114/FT1114/TT1114)
<input type="checkbox"/> BCR/ABL by PCR Quantitative (BCRQT/BMBCRQ/FBCRQT)	<input type="checkbox"/> Detection of t(14;18), DNA (T1418/BM1418/FT1418/TT1418)
<input type="checkbox"/> BCR/ABL Kinase Domain Mutation Analysis (BCRKDM)	<input type="checkbox"/> T Cell Clonality by PCR (TCLON/BMTCLO/FTCLO/TTCLO)
<input type="checkbox"/> B Cell Clonality by PCR (BCLON/BMBCLO/FBCLO/TBCLO)	<input type="checkbox"/> AML Prognosis Panel (FLT3, NPM1) (AMLp, BMAML)
<input type="checkbox"/> Janus Kinase 2 V617F Mutation (JAK2/NJAK2)	<input type="checkbox"/> CKIT Mutation Analysis (CKITMU)
<input type="checkbox"/> Micro Satellite Instability Colon CA (TMS)	<input type="checkbox"/> KRAS Mutation Detection (KRAS)
Note: Submit a normal block or peripheral blood (ETDA) with tumor sample	<input type="checkbox"/> PML/RAR t(15;17) by PCR (T1517/BM1517/FT1517/TT1517)
<input type="checkbox"/> EGFR Gene Mutation Panel (EGFRP)	<input type="checkbox"/> MGMT Promoter Methylation Detection (MGMT)

STANFORD ONCOLOGY 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.

Flow Cytometry		Lab Phone Number: (650) 724-2250
Blood	<ul style="list-style-type: none"> · 4mL Whole Blood · Lavender-top (EDTA) tube · Maintain specimen at room temperature · Peripheral Blood Smear (Requested but not required) 	
Bone Marrow	<ul style="list-style-type: none"> · 4mL Bone Marrow · Lavender-top (EDTA) tube or Green-top (sodium heparin) tube · Maintain specimen at room temperature · Aspirate Slide (Requested but not Required) 	
Core Biopsy or Fresh Tissue	<ul style="list-style-type: none"> · 0.5-1 cm³ tissue biopsy · Sterile tube containing RPMI cell media · Maintain specimen at room temperature 	
Fluid (pleural, effusion, ascites etc.)	<ul style="list-style-type: none"> · 7ml of fluid · Lavender-top (EDTA) tube or Sterile tube · Maintain specimen at room temperature 	
Chromosome Analysis		Lab Phone Number: (650) 725-6396
Blood	<ul style="list-style-type: none"> · 4mL Whole Blood · Green-top (sodium heparin) tube · Maintain specimen at room temperature · Blood must have circulating blast when bone marrow is unobtainable 	
Bone Marrow	<ul style="list-style-type: none"> · 1-2 mL Bone Marrow · Green-top (sodium heparin) tube · Maintain specimen at room temperature 	
Tissue	<ul style="list-style-type: none"> · 0.5-1 cm³ tissue biopsy · Sterile tube containing RPMI cell culture media, Sterile saline acceptable if media unavailable · Maintain specimen at room temperature 	
Molecular Pathology		Lab Phone Number: (650) 723-6574
Blood	<ul style="list-style-type: none"> · 4mL Whole Blood · Lavender-top (EDTA) tubes · Consult Lab Guide for Specimen Handling :RNA Studies –ship on wet ice, DNA Studies ship at room temperature 	
Bone Marrow	<ul style="list-style-type: none"> · 1-2 mL Bone Marrow · Lavender-top (EDTA) tubes · Maintain specimen at room temperature 	
Tissue	<ul style="list-style-type: none"> · 0.5-1 cm³ tissue biopsy · Frozen Tissue -maintain frozen and send on dry ice · Fresh Tissue -Send sterile tube containing RPMI cell culture media · Paraffin embedded tissue 	
Fluid	<ul style="list-style-type: none"> · Volume varies, contact laboratory · Sterile tube · Maintain specimen at room temperature 	
Fluorescence in situ hybridization (FISH)		Lab Phone Number: (650) 725-6396
Blood	<ul style="list-style-type: none"> · 4mL Whole Blood · Green-top (sodium heparin) tube · Maintain specimen at room temperature 	
Bone Marrow	<ul style="list-style-type: none"> · 1-2mL Bone Marrow · Green-top (sodium heparin) tube · Maintain specimen at room temperature 	
Tissue	<ul style="list-style-type: none"> · Paraffin embedded tissue 	

Chromosome Analysis and FISH testing can be performed from a single patient sample if volume is adequate.

First sample collected should always be a Green Top (sodium heparin) tube when Chromosome Analysis is requested

<p>SHIP TO: Stanford's Anatomic Pathology and Clinical Laboratory Attn: Specimen Processing 3375 Hillview Avenue Palo Alto, CA 94304 Phone: 1 (877) 717-3733</p> <p>if shipping Friday check for Saturday delivery</p> <p>Fax delivery notification to: (650) 724-4758</p> <p>Shipper's Responsibility: 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.</p>
