CytoGenX
Medical Genetic Laboratories

www.CytoGenX.com

1212 Rte 25A
Stony Brook, NY 11790
1-888-GENE-MED

ONCOLOGY TEST REQUISITION

Today's Date: / /

Name *(Last, First, M.I.):* ☐ M ☐ F		**DOB:**	**PCP:**
Street Address:	**City:**	**State:**	**ZIP:**
Social Security #:	**Home Phone:** ( ) -	**Work Phone:** ( ) -	

INSURANCE INFORMATION

Primary insurance: (attach copy of card)		Secondary insurance: (attach copy of card)	
Policy ID#:	Group #:	Policy ID#:	Group #:
Policy holder's name:	DOB:	Policy holder's name:	DOB:
Policy holder's SS#:		Policy holder's SS#:	
Relation to policy holder: ☐ self ☐ spouse ☐ child ☐ other		Relation to policy holder: ☐ self ☐ spouse ☐ child ☐ other	

REFERRING PHYSICIAN/FACILITY

Facility Name:	Referring Physician:	
Reporting Address:	Genetic Counselor/Contact:	
Reporting Phone: ( )	Reporting Fax: ( )	NPI #:

CLINICAL INFORMATION

Sample Type: ☐ Peripheral Blood ☐ Bone Marrow ☐ Fresh tissue Biopsy ☐ Bone Core ☐ Lymph Node ☐ Urine ☐ paraffin embedded section

Date drawn: / /	Time Drawn:_____ AM/PM	Date Sent: / /
WBC _____ % Blasts _____ ☐ Pre-transplant ☐ Post-transplant		Has patient received a bone marrow transplant? ☐ Yes ☐ No Donor sex: M / F

Disease status: ☐ New leukemia ☐ Remission ☐ Relapse ☐ Know Down Syndrome ☐ Primary solid tumor ☐ Metastatic tumor

INDICATIONS/Suspected Diagnosis (Required)

ICD 9 Dx code(s): _____ (required)

☐ Acute Lymphocytic Leukemia (ALL)	☐ Hematuria	☐ Neutropenia
☐ Acute Myelocytic Leukemia (AML)	☐ Leukocytosis	☐ Non-Hodgkin Lymphoma (NHL)
☐ Acute Promyelocytic Leukemia (APL)	☐ Leukopenia	☐ Pancytopenia
☐ Adenopathy	☐ Leukemia	☐ Polycythemia Vera (PV)
☐ Anemia	☐ Lymphoma	☐ Retinoblastoma
☐ Bladder Cancer	☐ Lymphocytosis	☐ Sarcoma
☐ Breast Cancer	☐ Lymphoproliferative Disorder	☐ Thrombocytopenia
☐ Burkitt Lymphoma	☐ Monoclonal Gammopathy	☐ Thrombocytosis
☐ Chromic Myelogenous Leukemia (CML)	☐ Multiple Myeloma	☐ Waldenstroms
☐ Chronic Lymphocytic Leukemia (CLL)	☐ Myelodysplastic Syndrome or Disease (MDS)	☐ Wilms Tumor
☐ Ewing Sarcoma	☐ Myeloma	☐ Other: (specify)_____
☐ Hodgkin Lymphoma	☐ Myeloproliferative Disease (MPS or MPD)	

LABORATORY TESTS ORDERED

☐ Chromosome Analysis Peripheral Blood	☐ FISH:	☐ Breast Cancer HER2-nue (FISH) PathVysion™
☐ Chromosome Analysis Bone Marrow	☐ X/Y [opposite sex BMT]	☐ Bladder Cancer UroVysion™ (FISH)
☐ Chromosome Analysis Solid Tumor	☐ Reflex if cytogenetics is NORMAL	
☐ CGH Microarray	☐ FISH (as appropriate for diagnosis)	
☐ Other: _____	☐ Other: _____	

For Regulatory Compliance The Following Consent Must Be Completed and Signed by the Physician and the PATIENT:
This patient received appropriate information about the nature of the testing process and gives informed consent to be tested.

Physician's Signature: _____ Date: / /

I hereby acknowledge that I have received information regarding the nature of the testing process and give my consent to be tested. I understand that my sample is not being banked. Once my test is completed, my DNA may be used anonymously (stripped of identifiers) for research or control purposes. I hereby authorize my insurance benefits to be paid directly to CYTOGENX, and authorize the release of any medical information concerning my testing requested by my insurer. I authorize CYTOGENX to initiate any complaints to the insurance commissioner on my behalf. I hereby acknowledge that I am financially responsible for any amounts not paid by my insurer, including related collection costs, all reasonable attorney fees and late interest penalties assessed on delinquent accounts. I hereby authorize CYTOGENX to charge my credit card for any patient responsibilities not covered by my insurance plan.

Patient (or Guardian) Signature: _____ Date: / /

Credit card Number: _____ Expiration Date: / /